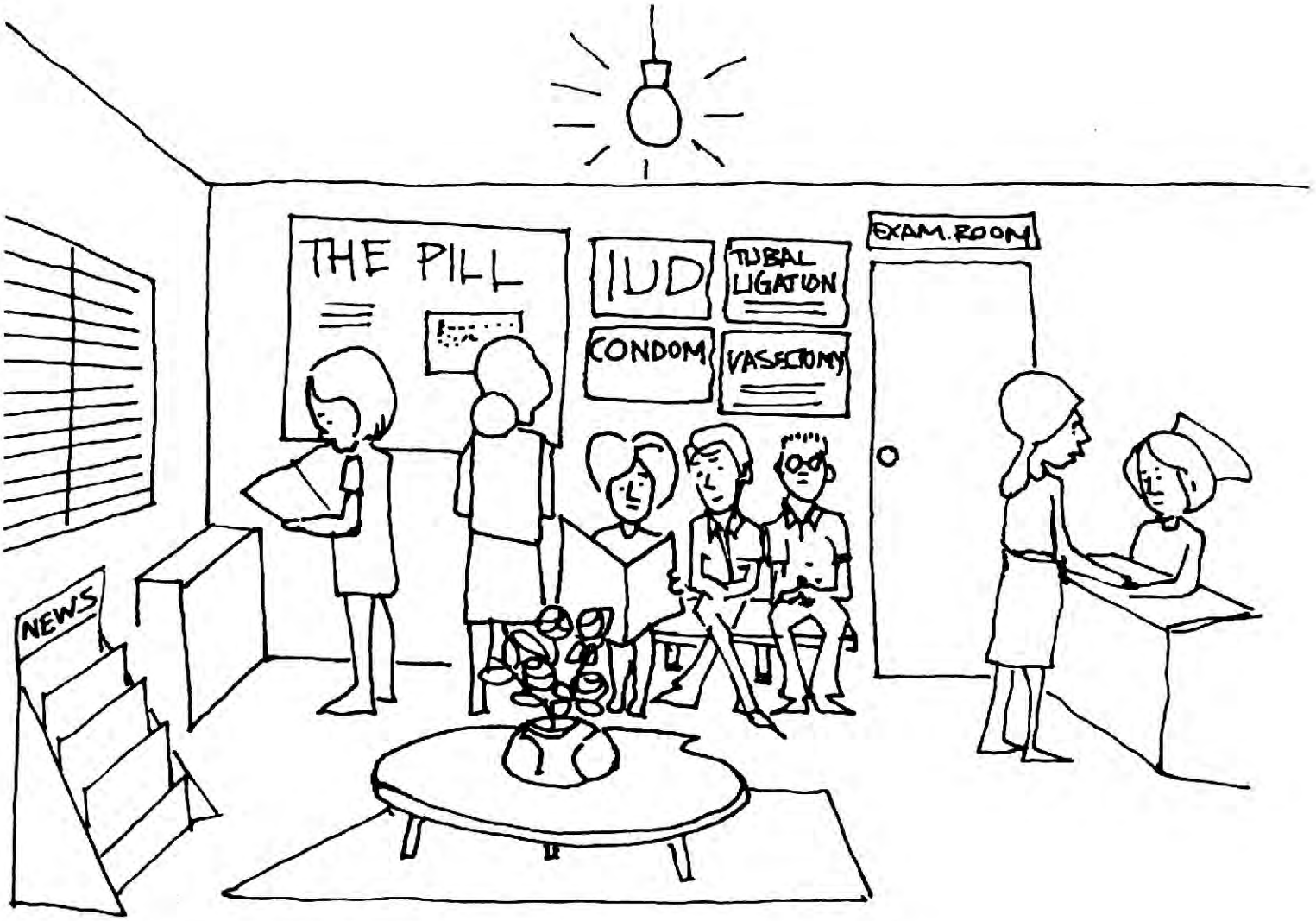

CLINIC EDUCATION

Sanford Danziger, Victor T. Valbuena, and Jan Brittain-La Brie

A PROFESSIONAL DEVELOPMENT MODULE

EAST-WEST COMMUNICATION INSTITUTE

EAST-WEST CENTER

Module Text

CLINIC EDUCATION

by

Sanford Danziger, M. D.

Victor T. Valbuena

Jan Brittain-LaBrie

Module Text

PROFESSIONAL DEVELOPMENT MODULES

A series of learning modules for professional and administrative staff working in development communication programs.

• John Middleton, General Editor

East-West Center
East-West Communication Institute
Honolulu, Hawaii

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FOREWORD

Any discipline faces the challenge of translating what it learns from research and practice into a form usable by persons who apply knowledge to problems. This challenge is particularly demanding in the field of economic and social development, and nowhere more so than in trying to inform and educate people about the problem of population.

Population problems exist, in one form or another, throughout the world. To help solve these sensitive and difficult problems, a large number of countries depend upon a group of professionals working in what has come to be called Population IEC (information, education, communication). These professionals, working under great difficulties, often isolated from the sources of learning, feel a continuing need to stay abreast of latest knowledge in their field. The East-West Communication Institute, under the general supervision of Dr. Robert Worrall and the specific direction of Dr. John Middleton, and with the support of the U.S. Agency for International Development, has made an effort to respond to this need.

The Modular Learning Materials, of which this is one unit, are not quite like any other learning materials in the subject area. They have been developed with the aid of scholars and practitioners, and tried out by representatives of the audience for whom they are intended: working professionals. Consequently, they represent a blend of theory and practice in what we believe is a usable form and one we hope will be widely helpful.

Wilbur Schramm

EDITOR'S INTRODUCTION

These materials are part of a series of development modules designed and produced at the East-West Communication Institute to assist professionals working in population and family planning information, education, and communication (IEC) programs in sharpening their professional skills. A wide range of expertise--drawn from IEC programs in Asia and the United States, from universities, and from the Communication Institute staff--has been brought to bear on the development of the materials. Acknowledgement of authorship is given in each module. The project has been supported with a grant from the U.S. Agency for International Development.

We began this project with the major goal of producing professional instructional materials which, in addition to serving as the core of population IEC professional development programs at the Institute, could be adapted and used in a variety of training and development settings. To this end we have attempted to make each module as complete and self-sufficient as possible. The modules are self-instructional to lessen the burden on teaching and training staffs, and to facilitate their use on an individual basis. We have built the modules around real life cases, problems, examples and data, and have sought at all times to strike a balance between principles and techniques for practical application.

A basic premise of our work with the modular materials is that they will be constantly revised. As we use the materials in Honolulu, and as cooperating institutions use them in other institutional settings in Asia, Africa, Latin America, and the United States, we receive feedback which helps us refine and improve the modules. We are especially grateful to the 40 participants from Asia, Africa, Latin America, and the United States in the First Modular Program of Professional Development in Population and Family Planning IEC who helped us conduct the first full field test of the materials in Honolulu in the spring of 1974. Their critical review and commentary has been a rich source of ideas for improvement. We owe a similar debt of gratitude to the numerous IEC experts around the world who reviewed and criticized the materials. A special vote of thanks is due the Planned Parenthood Federation of Korea, which has generously shared with us the results of their project to review, revise, and adapt modules for their own use.

Recognizing the need for continual improvement of the modules, we are nonetheless sharing them in this "second revised form." We encourage nonprofit education and training institutions to use the materials, revising, adapting, translating and tailoring them to meet their needs. We would be grateful for feedback on the nature and results of such efforts.

We intend to continue developing existing modular materials and will be adding modules as the need arises. Institutions interested in obtaining copies of the modules and audiovisual support materials are encouraged to write to the Communication Institute for more details.

The conceptualization and coordination of the project has been the work of the Task Group for Modular Professional Development. Without the creativity and hard work of these people, there would have been no modular materials: Ronny Adhikarya, George Beal, Jerry Brown, Ellwood B. Carter, Sanford Danziger, James R. Echols, O. D. Finnigan, Francine J. Hickerson, Ying Ying Hsu, D. Lawrence Kincaid, David Kline, Sumiye Konoshima, Jan LaBrie, Iqbal Qureshi, David Radel, Syed Rahim, Merry Lee San Luis, John Shklov, Mary-jane Snyder, Victor Valbuena, Hichul Whang, Margaret White, and Robert P. Worrall.

This project was supported by the Office of Population, U. S. Agency for International Development, AID/csd-1059. Special thanks are due to Dr. Wilbur Schramm, whose guidance has been essential, and to Dr. Robert P. Worrall, who, as Assistant Director, gave this project the support needed to transform an idea into reality.

John Middleton
Honolulu, 1977

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OVERVIEW

The backbone of family planning programs is made up of the thousands upon thousands of clinics, large and small, where men and women throughout the world who seek family planning services go for assistance. As a primary contact point between a program and the clients to be served, clinics are the place where the essential job--providing clients with services--is done.

But the provision of contraceptive services, in most clinics, is by itself not enough. Clients need to learn many important things about family planning, about the methods available, and about the method they select. Providing this information is what clinic education is about--and this module is about how clinic education can be made more effective. In particular, this module focuses on ways education in clinics can help overcome a serious problem facing family planning programs today--the persistently high rate of discontinuation, or "dropouts," among current family planning users.

THE AUDIENCE OF THE MODULE

The module is addressed to clinic educators at work in Asia and the United States. This is a very diverse group of people, as it includes all individuals responsible in a reasonably direct way for the design and execution of education programs in clinics. Thus our audience includes medical people (physicians, nurses, para-professionals), health educators, volunteer staff, and administrators at various levels.

In designing the module for use in mid-career professional development programs at the East-West Center, we have tailored it for clinic educators with, on the average, three years of experience in family planning and an undergraduate college education, or equivalent. This audience has also been multi-cultural and multi-lingual.

GOAL AND OBJECTIVES

The broad goal of the module is to help clinic educators design programs that will lead to informed, satisfied, confident, continuous, and vocal users of contraceptive methods. This is an ambitious goal, yet one which we feel can be reached.

Specific learning objectives for the module may be found at the beginning of each unit. These objectives reflect the concepts that, when taken together and combined with the readers' own ideas and experience, can help them on the way towards achievement of the broad goal.

MODULE STRUCTURE

The module is divided into nine basic units. The first unit provides an overview of the rest of the module, and the second deals with that part of the clinic education program that educators cannot change or improve--the client. The remaining seven units each deal with an aspect of clinic education that educators can change and improve. The units are related, but can be used independently to work on selected parts of the clinic education process.

Units

Each unit follows the same basic format, containing these components:

Unit Objectives--tells readers what they can expect to learn from completing the unit.

Getting Started with Your Own Experience--questions or small problem cases designed to stimulate readers' thinking, bringing their experience and ideas to bear early in the unit.

Notes from the Experience of Others--summaries of the experience of the authors and others as it relates to the unit topic. Sometimes these notes are elaborate; other times they are not. This "content" depends on the nature of the topic, and the extent of available experience. Often the reader is asked to participate in the development of this section through questions and small exercises.

Summary--pulls together the main ideas of the unit.

Something to Do--a section containing exercises and activities built around the ideas in the unit. It is intended primarily for use in group learning situations.

Self-Test--a brief exercise to give readers feedback on their accomplishment of unit objectives.

Notes and Reaction Page--a place for the readers to have the last word, to comment on the ideas in the unit, to record ideas of their own, and in group learning situations, to prepare for discussion.

Supplementary Readings

These selected readings support the module text. There is also a References section following the Module Manager's Guide.

Module Manager's Guide

Finally, there is a brief guide to the use of the module in group learning situations. There are also some ideas on how the module might be adapted for use in different cultures and organizations.

A NOTE ON THE AUTHORS

Dr. Sanford Danziger, the principal author of this module, is a physician and health educator who has worked with family planning communication programs in a number of countries. Dr. Danziger was on the staff of the East-West Communication Institute from 1971-74. Victor T. Valbuena has held a series of posts in clinic education in the Philippines and is now with the Population Center Foundation. Jan Brittain-LaBrie has conducted research and designed clinic education programs for Planned Parenthood of Chicago since 1973.

UNIT I

CLINIC EDUCATION:

Why It Is Important

What It Is

What It Should Do

How It Can Be Improved

UNIT OBJECTIVES

When you have completed this unit, you should be able to:

1. Identify the primary audience for education in family planning clinics.

2. Identify the major family planning program problem that effective clinic education can help solve.

3. List at least five client problems that can lead to client dropout.

4. List four goals of clinic education.

5. List seven aspects of the clinic education program which can be changed to improve program performance.

GETTING STARTED WITH YOUR OWN EXPERIENCE

The exercise below is designed to help you begin this unit with your own experience and ideas. Answer the following questions:

1. Which group of people (or "audience") can benefit most from education in family planning clinics?

   _____

   _____

2. There are many problems in family planning programs. In your opinion, which problem can effective clinic education best help solve?

   _____

   _____

3. Program dropouts (people who stop using contraception or who switch to a less effective method) are increasing in most family planning programs. In your opinion, what are some of the major reasons for "dropouts"?

   _____

   _____

   _____

   _____

   _____

   _____

4. What should be the goals of clinic education? List at least four goals, and briefly explain why each is important.

5. From your experience, what are the aspects of the clinic education program that clinic administration can change or modify to improve program performance?

6. How high is the client dropout rate at your clinic in comparison with other clinics at the end of one or two years?

7. What are causes of high dropout rates? What kinds of things happen when clients go home which tend to make them drop out?

8. What have you personally done to help decrease the dropout rate?

9. Are family planning administrators at the national level and/or at the local level very concerned about the dropout rate? Why "no" or "yes"?

NOTES FROM THE EXPERIENCE OF OTHERS

Clinic education often has low priority among administrators. This is unfortunate, because clinic education reaches a very important family planning audience--current users, including those people who are accepting a family planning method for the first time. Moreover, good clinic education for this audience can help solve one of the most important problems facing family planning programs today--the high rate of dropouts.

CLIENT PROBLEMS AND DROPOUTS

Better client education can help decrease the high dropout rate. When clients return home from the clinic they are faced with many difficulties, all of which can cause them to discontinue using contraceptives. Education can help solve those difficulties.

Clients may tend to discontinue a method unless:

1. They feel confident that they know how to use it.
2. They have been prepared for possible side effects and so are not afraid when they happen.
3. They know some ways to diminish side effects.
4. They feel that the clinic is a warm, accepting place where they can return easily if they have problems.
5. They have enough confidence in their methods and do not become frightened when the rumors about that method appear.
6. They have learned that family planning is a popular thing to do and that they are not the only ones in the area using a method.
7. They can confidently explain some things to their spouses when they are asked questions: "No, I won't be sterile after discontinuing the method." "My health in fact should be better when I don't have children one after the other." "The vasectomy won't affect our sex life."
8. They can answer with some confidence the questions their relatives and friends will certainly ask about this new thing they are doing.
9. They feel confident and proud that they have made a wise decision to practice family planning.
10. A woman does not get panicky, and knows what to do when she discovers that she has forgotten to take a pill for one day, or for two days.

A MAIN GOAL OF CLINIC EDUCATION IS TO PREPARE THE CLIENT FOR THE MANY FRIGHTENING RUMORS HE/SHE HAS ALREADY HEARD AND THE MANY MORE THAT WILL BE HEARD.

These difficult situations happen most often for women; frequently two or three of these things happen at the same time, plus many other things not listed. It's a wonder that even more clients don't "dropout"!

The education that clients receive at the clinic can help them "get through" all of the above problems and situations, which they are almost certain to encounter, and which tend to make them "dropout." Indeed there is a good chance that it is only at the clinic that they are able to get the information which is needed to be a continuing user. (Of course, by "clinic education" we also mean the kinds of education that the clinic can arrange for, once the client is back home, such as follow-up house visits, satisfied users, literature, etc., as discussed in a later unit of this module.)

SIDE EFFECTS AND DROPOUTS

There are few available studies of the "causes" of dropouts, and they do not give a very true picture of what the real causes are. They often cite "side effects" or "pain" or "bleeding" as the "cause." What they do not show, however, is the considerable proportion of clients who had only a relatively small amount of "side effects," etc. but whose "side effects" were greatly magnified in their minds because of uncertainty and fear. Such magnifications, even of things like headaches, are caused by combinations of the following:

1. Fear: This is something deadly, like the rumors and stories which say: "Cancer," "internal hemorrhage," "traveling to my brain."

2. Uncertainty: "How long is this side effect going to last?" "Is the side effect normal?"

3. Not knowing what to do: Should the client tell someone in the village about a side effect? Should she/he wait? If so, how long? Should she/he leave the family and journey again to the clinic? Would the clinic be open?

We have all experienced this mental magnification of our symptoms or pains. It can cause severe anguish, even to ourselves--educated, sophisticated people. Certainly medical people understand this symptom magnification better than anyone, since we are always seeing the strong influence which the mind has on symptoms of every kind. It's also part of our own life experience. Don't we

remember how, as sophomore medical or nursing students, we and our colleagues were sure we had the fatal illness we were studying that week?

Magnify that fear even more, since it is in the mind of an uneducated, illiterate villager, exposed to rumors, with some fearful symptoms, far from a clinic, who doesn't know where to turn, and who spends days and nights with alternating panic and hope. "It stopped for now. Perhaps I don't have cancer!!"

The client is finally worn down with concern and decides to discontinue the method. Later, if a doctor asks (in a "dropout study") why the client discontinued, the answer will be whatever physical symptom the client had, and that will be written down as the "cause." But we know that it's far more complicated than that.

And perhaps we can be more hopeful, since good clinic education can help overcome some of those things which magnify the clients' side effects or worries. And it can teach them to deal with naturally-inquisitive spouses, skeptical mothers-in-law and rumor-carrying neighbors.

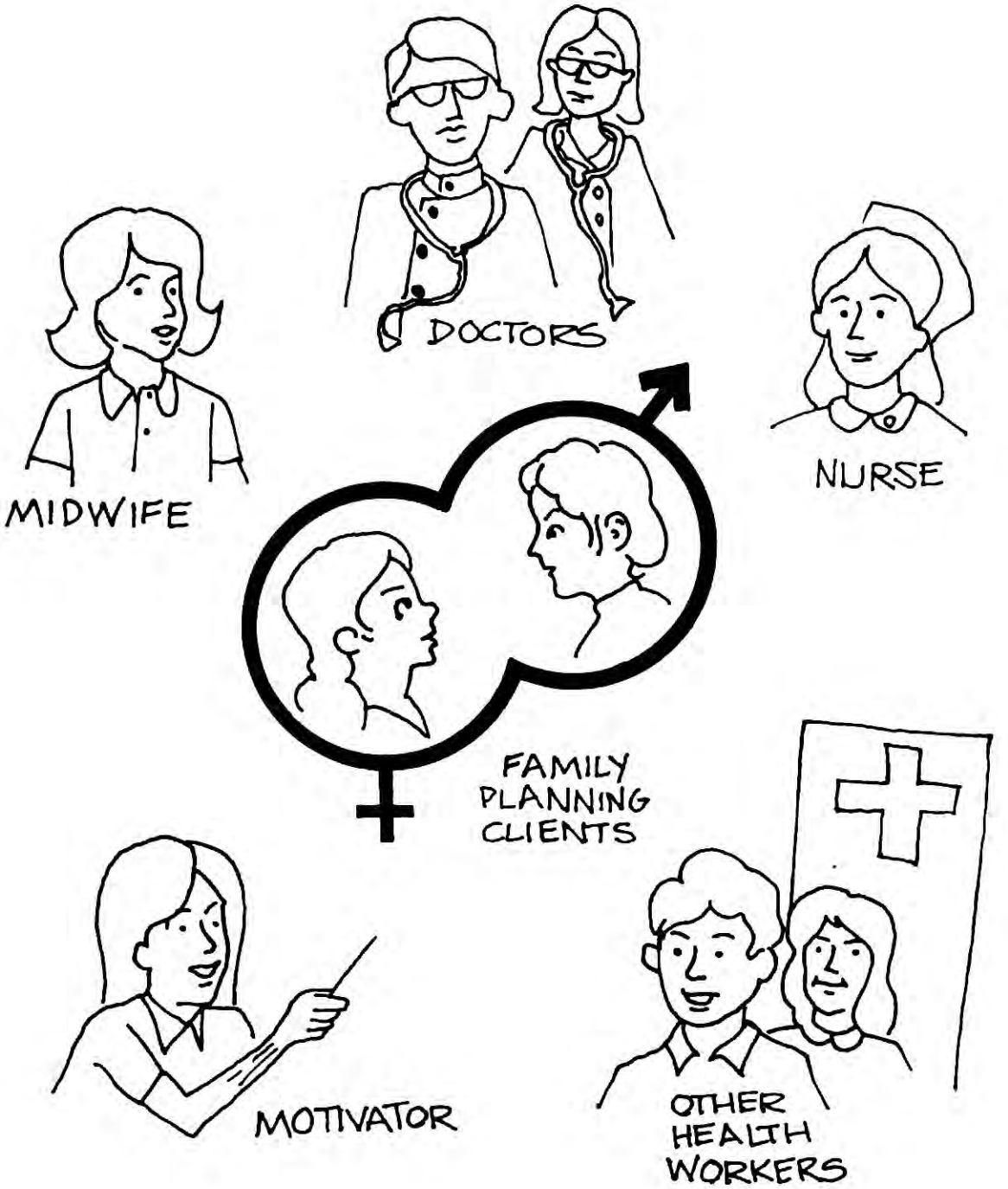
WHAT IS CLINIC EDUCATION?

Clinic education is the in-house, in-clinic, in-dispensary process of providing family planning clients with information, instruction, reassurance, and support so that they will do the following:

1. Choose a method of contraception.
2. Use it properly.
3. Manage it with comfort and assurance.
4. Maintain a continuing relationship with the clinic.
5. Internalize the concept of family planning as a means toward a better quality of life.

Clinic education is also known as client education or patient education. This is so because at other times, education is not conducted within the family planning clinic setting. Other settings may be the postpartum ward, pediatric clinic, or the client's home during acceptor recruitment or revisits and follow-ups.

Many family planning communicators prefer to use the word client over clinic or patient because the person who comes to the family planning clinic is not necessarily sick. He or she may generally be active and healthy.


DOCTORS
MIDWIFE
NURSE
FAMILY PLANNING CLIENTS
MOTIVATOR
OTHER HEALTH WORKERS

Clinic education is communicating with clients in a way that will ease their minds whether they are first-time visitors or revisit and check-up clients in the clinic.

Clients coming to the clinic are generally ill at ease. They do not usually know what is going to happen to them in the clinic. Through communication, clinic personnel may be able to ease their fears and assure them that things will be all right--that whatever anxieties they may have may be relieved by competent and concerned staff who will be ready, willing, and able to attend to their needs.

Clinic education is answering the relevant questions posed by family planning clients. It is explaining to highly educated clients not only the positive aspects of using contraceptives but also its negative facets to provide a sound basis for intelligent choice of family planning method. It is describing and emphasizing to less educated clients the more positive side to contraception rather than the negative in order not to confuse them.

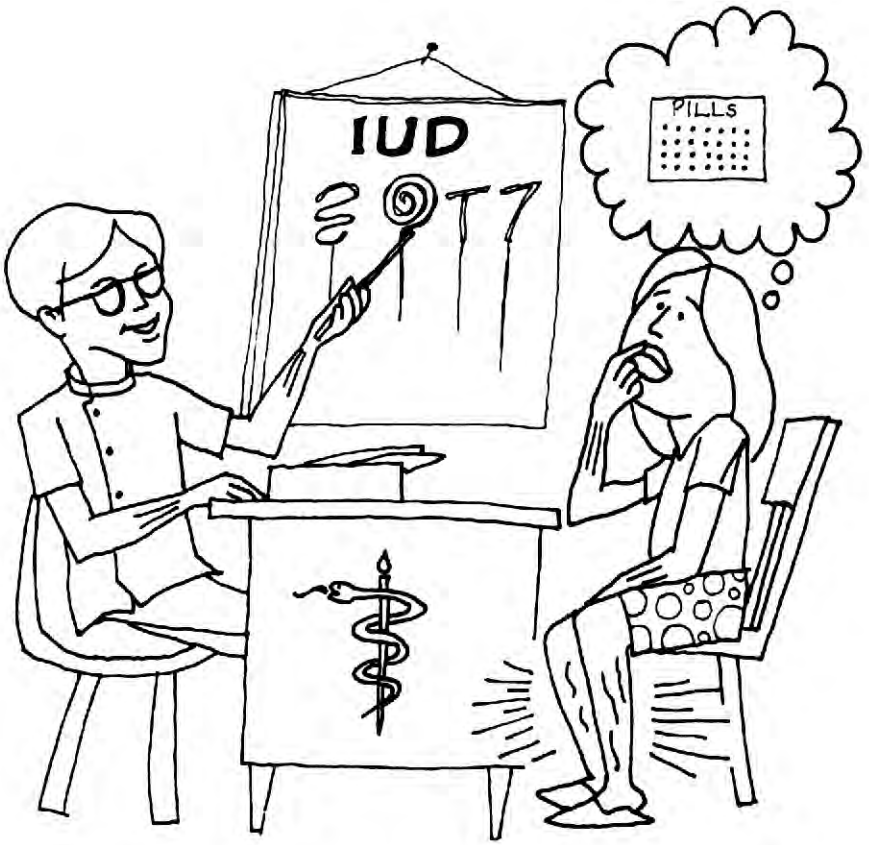
Generally, clinic first-timers do not ask too many questions. However, they do have many questions at the back of their minds. Is the method safe? Is it reliable? What are the side effects, if any? Will it interfere with marital sexual relationships? Should children be desired later, will they be born normal?

Clinic education is <u>reassuring clients who have doubts about one or more aspects of particular contraceptive methods</u>.

After a client leaves a family planning clinic, he or she is open to rumors which may cause doubts about particular methods already chosen. A man who hears from his office mates that vasectomy leads to impotency may waver and begin to doubt his capacity to perform sexually after the operation. Fearing for his wife's health, a man may decide not to allow his wife to try the IUD, because he has heard rumors that the device causes a lot of ectopic pregnancies.

Through clinic education, clients can be made to feel confident enough about their methods. Then they will not become apprehensive when they are faced with rumors in their towns or villages.

Clinic education is <u>reinforcing positive decisions already made about family planning.</u> It is providing alternative options if a particular method of choice is not suitable to the condition of the client.



Many times, a client who comes to the clinic has already decided on a particular contraceptive method. Many times, however, the method chosen may not be suitable for that client. For example, a woman who has varicose veins may insist on taking the pill. Through clinic education, family planning personnel can encourage clients to go on with their plans for child limitation or birth spacing, but to choose methods more suitable to their conditions.

WHAT ARE THE GOALS OF CLINIC EDUCATION?

Family planning education conducted by clinic personnel aims to produce the an acceptor possessing the following characteristics:

1. *A continous acceptor, not a dropout*

This means that the clinic and its personnel should provide continuous motivation, information, education, support and reassurance, whether inside or outside the clinic walls.

Clients returning home from the clinic, for example, face many difficulties. They may not remember instructions correctly, may be apprehensive about possible side effects, may hear rumors about the methods they are using, or may face pressures to discontinue family planning practice from in-laws, spouses, neighbors, and friends.

The quantity and quality of education that clients receive may help them overcome the above situations which may lead them to drop out of the program.

2. *An informed, confident acceptor, one who will not easily become frightened by rumors or a temporary side effect*

This means educating clients at the time they are in the hands of clinic personnel; it means providing them with information on the availability and relative advantages/disadvantages of the various contraceptive methods to help them make an intelligent choice. It implies providing the clients with information and support so that they may feel confident in the knowledge that they know how to use and manage their methods properly; so that they are prepared to cope with side effects that may come up; so that they may not be frightened when rumors and misconceptions about their methods come up in their villages; so that they can confidently tell their spouses that having an IUD, or using any other contraceptive for that matter, will not effect their sex life; so that they can confidently answer questions from relatives and friends who may discourage them from continuing on with their family planning practice.

3. *A satisfied acceptor, one who is relatively satisfied with the method used as well as with the reception and service received at the clinic*

This means that clients will be satisfied if the education program can provide them with clear, easy-to-remember instructions on how to use and manage whatever methods are used; if the program answers their informational needs; if the clinic staff provides them with the right quantity and quality of services they need; if clients feel that the clinic is a warm, accepting place where they can return easily if a contraceptive problem arises; if they feel that the clinic treats them as people, not as a statistical entry in the performance chart; if they feel that the clinic is a pleasant, even interesting place.

4. *A vocal acceptor, one who will readily and actively tell others about the successful use of contraception or sterilization methods, as well as the successful use of clinic facilities*

This means that the clinic should encourage the satisfied acceptors to tell their relatives, neighbors and friends about their successful use of family planning methods. The vocal acceptor, in business terms, is the "satisfied customer" so crucial to every successful sales campaign. The vocal acceptor is especially important, because, as many family planning studies have shown, most potential acceptors hear and are convinced about family planning mainly by word of mouth, from satisfied clientele.

For clients to be vocal about their experiences with family planning, they must first have fulfilled the requirements above: (1) be a continuing acceptor, (2) be knowledgeable enough to use and manage a method properly and also feel confident enough about this knowledge to explain some basic facts to others, and (3) feel satisfied enough to recommend the method and also the local clinic and its staff to others.

WHAT ARE THE PROGRAM AREAS OF CLINIC EDUCATION?

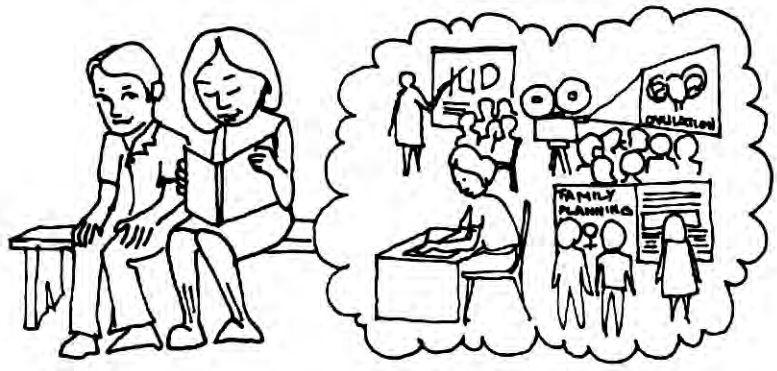
To design an effective clinic education program, we must take several aspects of the education program into account. These are the factors in the clinic that administrators and clinic personnel can change or modify in order to produce a continuing, informed/confident, satisfied and vocal user.

Among the most important of these factors are:

1. *The messages that the clients receive*

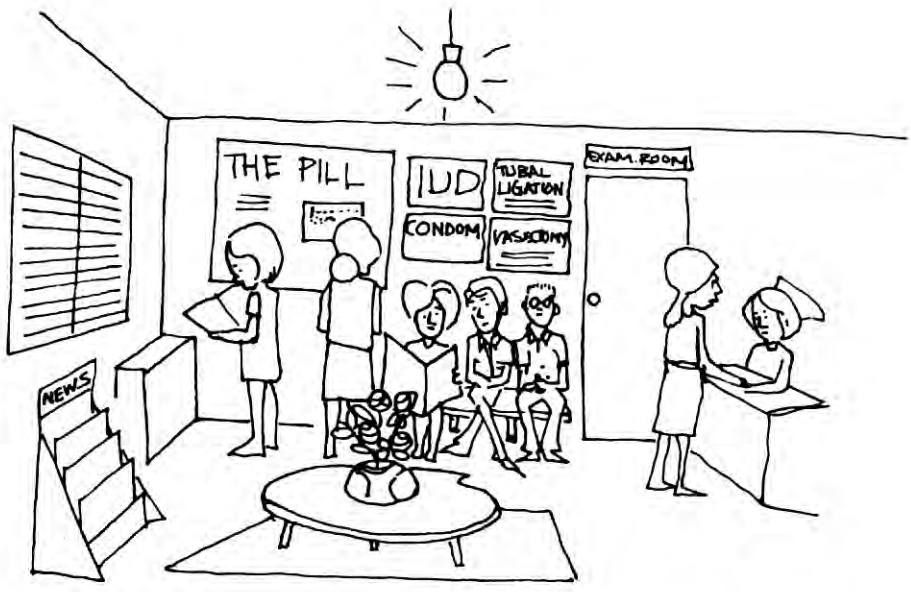
Are the messages appropriate to the clients that the clinic serves? Is there too much or too little information being given the clients? Are the messages one-sided in their presentation?

2. *The educational methods and supportive IEC materials used in the clinic*



What are the methods used by clinic staff when communicating with the clients? Lectures? Discussions? Demonstrations? Audiovisual projections? Are they suitable to the level of clients being served? Are there materials to read during client waiting time? Do the visuals used with clients relate to their experiences? Are they colorful? Interesting? Localized? Are take-home materials available? Are they easy to understand?

3. *The clinic setting and atmosphere*



Is the clinic accessible? Does it observe regular hours? Are the facilities warm and pleasant? Are they clean? Does the clinic provide privacy during interviews and during internal examinations and IUD insertions? Is the clinic spacious? Or is it cramped and overcrowded? Is there a waiting room where clients may comfortably await their turns to be served? Is there enough space to conduct clinic education lectures and discussion?

4. *The clinic staff–their attitude and training*

Are the clinic personnel friendly? Do they show genuine concern for the clients? Can they empathize with the needs of the clients? Are they conscious of their status thereby creating a gap between them and their clients?

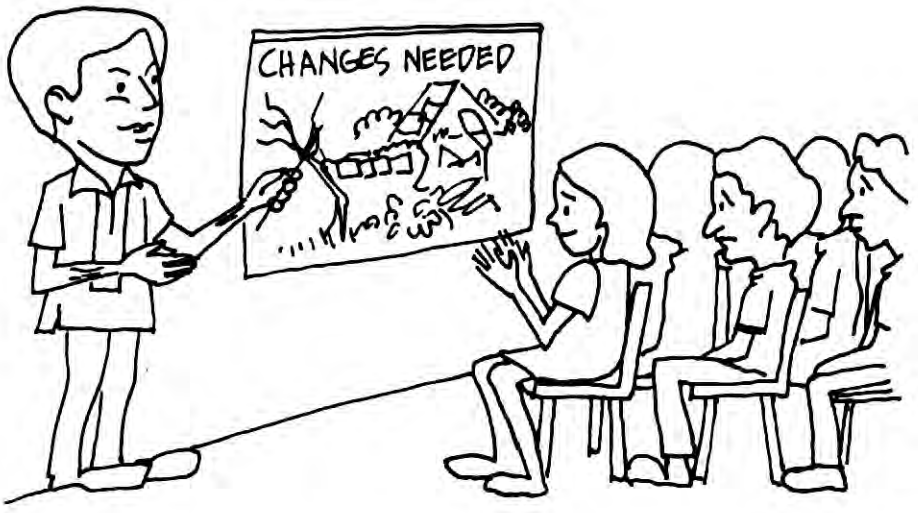
5. *The evaluation methods used*

Are clients being effectively informed, instructed, and motivated? What are the different ways the clinic staff can know if the clients can remember and explain what has been taught to them in the clinic?

6. *Follow-up and continuing education in the community*

In what ways does the clinic arrange for educating, motivating and supporting clients when they leave the four walls of the family planning clinic, when they go back to their communities?

7. *Administrative changes*



What changes in the system at higher levels are possible to insure that client education is given adequate priority and support?

Mentioned above are the seven component areas of clinic education where changes and modifications can be made to make sure that family planning clients become continuing acceptors.

There is one other important component of clinic education. This is the clients* and their characteristics as they affect understanding and learning. The client aspects of educational level, distance of home from the clinic, and exposure to fearsome rumors are the things the clinic staff cannot change. It is therefore our job to adjust the other seven aspects of clinic education to fit with the clients' needs.

Because we must build our programs to fit client needs, we will take up this topic first (in the next unit).

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*In this module we have used the term "clinic education" and "client education" interchangeably. This is because some people will not necessarily be in a family planning clinic. Some may be "clients" in postpartum wards or OB-GYN clinics, or at pediatric clinics with their children. In these latter cases there may, of course, be some differences in the educational approach. Most of the principles we discuss will apply to any "client" setting. The main focus of the Module, however, will be on the client in the family planning clinic.

At appropriate times in the module you may wish to consider how things would be different in another setting, like the postpartum ward, especially if your work involves settings other than the family planning clinic.

UNIT SUMMARY

1. Clinic education is given low priority by administrators in almost every country.

2. Clinic education reaches the special and important audience of current users, including people accepting a contraceptive method for the first time; it can therefore contribute to the solution of a major family planning program problem--high dropout rates.

3. The problem of high dropout rates should be the main argument used to convince administrators that clinic education needs improvement.

4. The main reason clients "drop out" is that they do not have the right kind of reassurance to carry them through the many difficult situations arising in the weeks and months after they return home from the clinic.

5. Clinic education programs should be based entirely on ways to help the client overcome those difficult problems and situations.

6. The "reasons" usually cited for why clients drop out do not give a true picture. They are mechanistic and represent only the "tip of the iceberg." For example, "pain" or "bleeding" is often cited as the "cause," but the true reasons are much more complex.

7. Clinic education should seek to achieve users who are continuous, informed and confident, satisfied, and vocal.

8. There are seven main areas of clinic education that can be changed to improve program effectiveness: message content, educational methods and materials, total clinic atmosphere (physical setting), clinic staff, evaluation methods, follow-up in the community, administrative systems.

SOMETHING TO DO

The exercise below has been provided to stimulate more thinking on the ideas in this unit. It can serve as the basis for discussion sessions when the module is used by groups.

SUPPLEMENTARY QUESTIONS

1) What is the dropout rate in your country?

_____

2) Where can these figures be obtained?

_____

3) Where and how can you get information on the reasons why clients "dropout." How reliable is this information? (Note that many studies on dropouts give only a medical point of view, e.g., "bleeding." After reading parts of this Module you can see that "bleeding" may be only a minor symptom which was magnified in the client's mind by other factors. The "dropout" studies need to be made by anthropologists and other social scientists, and not only by physicians.)

_____

_____

_____

_____

_____

4) Please rank on the following scale (from 1 to 10) the extent to which you feel the clinic education program can influence the client's successful and continued use of a method. Compare your answer with others in your group and discuss.

1 2 3 4 5 6 7 8 9 10

Very little Very much

5) In trying to convince your own program administrators of the need to improve client education, what other reasons might you give besides the one that it could decrease dropout rates? List them below. For each of the reasons you list (including decrease dropout rates) put a number to the side of it to indicate its order of importance as a reason to improve client education. 1 = most important. 2 = next most important, etc.

A) Decrease dropout rates (1)

B) _____

_____ ( )

C) _____

_____ ( )

D) _____

_____ ( )

6) Circle the best answer: Family planning clients as an audience are (not usually) (sometimes) (usually) overlooked in an educational effort or campaign.

7) True or false: Circle the best answer.

In your country:

a) A satisfied client usually will influence two or more other people to come to the clinic for services.

True False

b) A dissatisfied client will almost always tell three or more other people not to come to the clinic for services.

True False

c) If you answered "true" for parts a) and b), what does that suggest about the influence of users to either help or hurt the program?

_____

SELF-TEST

Check your own progress by answering the following questions:

1. According to this unit, who is the primary audience for clinic education?

2. What is the major family planning program problem that clinic education can help solve?

3. List at least five problems that clients can have with contraceptive use, and explain how each can lead to client dropout.

4. List four goals of clinic education.

5. List seven aspects of the clinic education program that can be changed to improve program performance.

ANSWERS TO SELF-TEST

1. Current users of contraception, including those clients accepting a method for the first time.

2. Dropouts or program discontinuers.

3. Lack of preparation for side effects; lack of knowledge of ways to diminish side effects; confidence in the face of rumors; unwillingness to return to the clinic for advice and help; lack of knowledge that family planning is popular and widespread; lack of ability to explain family planning and contraception to others (such as a husband or wife); lack of confidence in own decision; lack of knowledge about what to do if a contraceptive (particularly the oral pill) is used incorrectly; actual side effects.

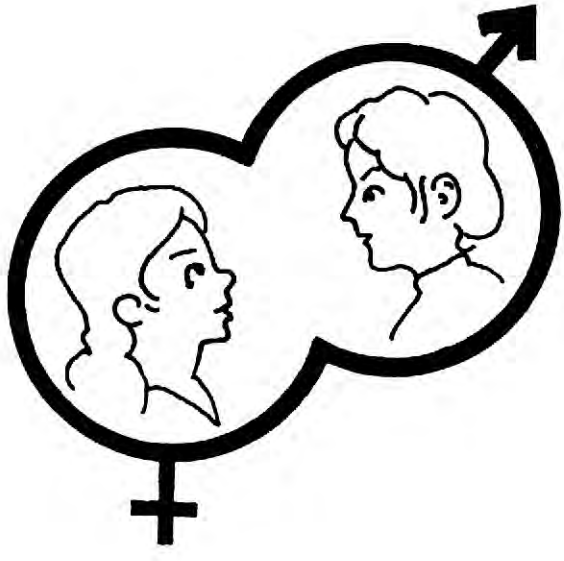
4. A continous user
   An informed, confident user
   A satisfied user
   A vocal user

5. Message content, educational methods and materials, total clinic atmosphere and physical setting, clinic staff, evaluation methods, follow-up in the community, administrative systems.

Notes and Reactions

UNIT II

THE CLIENT



UNIT OBJECTIVES

When you have completed this unit, you should be able to:

1. List at least five characteristics of audiences for clinic education that influence the way a clinic education program is designed.

2. Identify the educational implications of at least five client characteristics.

3. Given photographs of a clinic education setting, identify implications of that setting for educational programs.

GETTING STARTED WITH YOUR OWN EXPERIENCE

The experience below is designed to help begin the unit with your own experience and ideas. Answer the following questions:

1. What are the clients at your clinics like? Describe them in terms of their level of education, sex, and other characteristics that you think might be important for the design of a clinic education program.

_____

_____

_____

_____

_____

_____

2. Pick several of the characteristics in your answer to question 1. Then describe how a clinic education program should be designed to "fit" with these characteristics.

	Educational Implications
Characteristic 1:	_____
_____	_____
Characteristic 2:	_____
_____	_____
Characteristic 3:	_____
_____	_____

Characteristic 4: _____

_____ _____

Characteristic 5: _____

_____ _____

3. Describe the atmosphere and physical layout of your clinic(s). Where do people sit? What is the general atmosphere--happy, bright, dull, etc. ? How do you think your clients feel while they wait for services?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NOTES FROM THE EXPERIENCE OF OTHERS

Many times, clinic staff are overheard as saying, "What a stupid client! I have repeated the instructions so many times and she (he) still cannot understand. I think she (he) really has no brains!"

Little do these clinic personnel realize that generally, clients in a clinic setting find themselves in a strange and alien environment. Since this is a new experience, their capacities for understanding and learning in such an environment are diminished.

Typical clients are frequently not used to learning in the way the staff has planned for them to "learn" in the clinic. Ideally, they should be able to learn at the time they choose, from the persons they choose, at the speed they choose, in the place they choose, with the message content they choose, etc.

When clients are in the clinic, they also have many things on their minds which may inhibit them from absorbing and learning what is being discussed in the clinic. For instance, some clients are overheard to say:

"I don't know why Mrs. Cruz takes so long in explaining. Doesn't she realize I only dropped by the clinic on my way to the market? If she keeps on with her talk, all that I will find in the market are stale fish."

"Why does Miss Santiago always have to use English when she talks with me? She knows I only finished Grade II; she may sound impressive, but I don't understand a word she says!"

"My God! It's almost 11:00 and I haven't cooked our meal. My husband is coming home soon. This movie is taking so long. If only Dr. Santos would not feel slighted, I'll leave right away."

Clients cannot change their existing abilities to learn. But clinic personnel can make changes needed to adjust to the situation of the client.

Everybody learns things. Clients are no exceptions. Clinic personnel are challenged to discover and capitalize on the clients' existing capabilities to learn new things. At the same time they are challenged to overcome the problems of teaching and learning in the clinic setting.

UNIT SUMMARY

1. The clinic is in a strange and alien environment. Therefore, the capacities of clients for some kinds of learning are diminished in the clinic environment.

2. Typical clients are frequently not used to learning in the situation that we have established for them to "learn" in at the clinic --at the time we choose, from the person(s) we choose, at the speed we choose, in the place we choose, the message content we choose, etc.

   Since clients cannot change their existing abilities to learn (neither their learning "strengths" nor learning "weaknesses") it is up to us to make any needed changes.

3. Everybody learns things. Clients are no exception. As educators we are challenged to discover and capitalize on the clients' existing learning capabilities and at the same time discover ways to overcome the problems of teaching/learning in the clinic setting. This requires us to identify various characteristics of client subgroups.

4. The key to understanding what the typical client is like is to occasionally talk to them at length about many different kinds of things. In the clinics of every country, "developed" and "developing," this is seldom done.

5. Clinic settings can be evaluated in terms of clients, messages, methods and materials, general atmosphere and physical setting, clinic staff, evaluation methods, and community follow-up.

SOMETHING TO DO

The exercises below have been provided to stimulate more thinking on the ideas in this unit. They can serve as the basis for discussion sessions when the module is being used by groups.

Exercise #1: Identifying Client Subgroups

By describing clients in terms of various socio-demographic criteria, you can discover potential barriers to effective education. A first step in this process is to identify people coming to the clinic who are similar in terms of these characteristics, and who are therefore likely to be similar in terms of barriers to education. By dividing our general audience into subgroups in terms of language, sex, education level, and so on, we can then design our education program to meet their needs. We can also set priorities among these groups for our education effects.

Think of a subgroup of clients that form a large part of your clients, for example, low-income Catholics who are farmers. What kind of beliefs might the families of these clients have about birth control methods? Will the client have to keep coming to the clinic and use contraceptives secretly? Will there likely be strong negative attitudes and social pressures against birth control? How can this affect the motivation of the client to continue usage? What communication barriers does this set up for the client with his/her family? The clinic staff? How can these barriers be overcome? Think about the descriptions of each client group. What potential communication barriers do they show? How can these be overcome?

A number of characteristics useful in identifying audience subgroups are listed below. There is also space for you to add characteristics of your own. Think of the clients in your clinic(s). Then write down subgroups for each characteristic.

For example:

Characteristic	Subgroups
Sex	male/female

Characteristic	Subgroups
age groups	_____

Characteristics (cont.)	Subgroups (cont.)
income	
type of employment or work	
religion	
number of years of education	
literacy level	
geographical location	
language spoken	
culture	
current contraceptive practice (high or low; what method[s])	
status in community	
attitudes toward family planning	
how familiar with the clinic	
other:	
other:	
other:	
other:	

Once the characteristics of the clients have been identified, client groups can be listed in terms of importance (or "prioritized"). Think about which ones need the information the most. For first priority, you might want to consider:

- the client group which contributes most to the total birthrate.
- the younger clients who have more reproductive years ahead of them.
- the client groups with the lower rates of current contraceptive use.

What other groups can you think of that might be first priority? List them below:

_____

_____

_____

_____

_____

_____

_____

Once you've identified the characteristics of your client groups and what priority they will be, you need to think about the way the education will be conducted for these groups. To do this, you need to think of how these groups can best learn the information you want to convey.

Exercise 2 on the next page can help you think about these problems.

Exercise #2: Characteristics and Educational Implications of a Client Subgroup

The purpose of this section is to try to stimulate thinking about some of the characteristics of one of your typical client groups in the family planning clinic, as well as the educational implications of these characteristics. By knowing the client, we can design the educational system which best fits that "average" client. We are only listing some of those characteristics which affect the way that clinic "education" should be conducted.

First, identify the subgroup by age group and sex. Then rank order with a circle around the degree to which you feel the typical client in this group has that characteristic. Then, in the right margin write in the educational implications of each characteristic. We have given some examples. You should add more.

Client Group: _____ _____
sex age group

	Almost Always		Some-times			Rarely		I Don't Know	Educational Implications
	1	2	3	4	5	6	7		
1. Able to learn something after hearing or seeing it only one time.									A) Repeat the message several times B) Different staff members repeat C) Give illustrated take-home pamphlets D) _____ _____
2. Accustomed to learning things in life by the "lecture" method.									A) Use demonstration and group discussion B) Reduce lectures C) Use audiovisual materials D) Encourage client to ask questions E) _____ _____

	Almost Always			Some-times		Rarely		I Don't Know	Educational Implications
3. Has been to school less than 4 years.	1	2	3	4	5	6	7		A) _____ _____ B) _____ _____ C) _____ _____
4. Accustomed to learning things from peers, neighbors, relatives, etc.	1	2	3	4	5	6	7		A) Arrange for client to learn from other clients in and out of the clinic. B) Arrange so that client can later "teach" others both in and out of the clinic. C) _____ _____
5. Has previously had a doctor examine her/his sexual organs.	1	2	3	4	5	6	7		A) Find ways to decrease fear, suspicion, etc., on client's part and spouse's part. B) _____ _____ C) _____ _____

	Almost Always			Some-times			Rarely	I Don't Know	Educational Implications
6. Is nervous or anxious.	1	2	3	4	5	6	7		A) Calm anxiety so learning can take place. B) _____ _____ C) _____ _____
7. Is more nervous before the pelvic exam than after the exam.	1	2	3	4	5	6	7		A) Consider doing some education after the exam. B) _____ _____ C) _____ _____
8. Is illiterate.	1	2	3	4	5	6	7		A) Visual materials and demonstrations are important. B) If illiterate, may have learned to use her memory for specific items. This may be capitalized upon. C) _____ _____

	Almost Always	Some-times	Rarely	I Don't Know	Educational Implications
9. If she/he is illiterate, will actively seek and find someone at home to read her/him a "take-home" pamphlet.	1 2 3 4 5 6 7				A) Tell her to do this. Suggest ways to do it. B) _____ _____ C) _____ _____
10. Even if nervous, can still learn a lot from the clinic lecture.	1 2 3 4 5 6 7				A) _____ _____ B) _____ _____ C) _____ _____
11. Needs to have information repeated 3 times in order to learn it.	1 2 3 4 5 6 7				A) _____ _____ B) _____ _____ C) _____

	Almost Always			Some-times		Rarely		I Don't Know	Educational Implications
12. Has already heard some rumors that the family planning methods can harm her/him in some way.	1	2	3	4	5	6	7		A) Take rumors into account when doing the education. B) Get her/him to express or to discuss fears.
13. Will freely ask questions or start talking to a doctor or a nurse in the clinic.	1	2	3	4	5	6	7		A) Design ways to encourage this. B) _____ _____ C) _____ _____
14. Will freely ask questions or start talking with others waiting at the clinic.	1	2	3	4	5	6	7		A) Design ways to encourage this. B) _____ _____ C) _____ _____
15. If she/he has brought children, they distract her/him from learning.	1	2	3	4	5	6	7		A) _____ _____ B) _____ _____ C) _____ _____

	Almost Always			Some-times			Rarely	I Don't Know	Educational Implications
	1	2	3	4	5	6	7		
16. Comes to the clinic with confidence in the clinic personnel and in what they say.									A) If "yes," how to capitalize on this confidence. If "no," how to gain it. B) _____ C) _____
17. Leaves the clinic understanding the most important things about family planning.									A) _____ B) _____ C) _____
18. Add here any other characteristics you think are important.									A) _____ B) _____ C) _____

	Almost Always			Some-times			Rarely	I Don't Know	Educational Implications
19. (additions)	1	2	3	4	5	6	7		A) _____
									_____
									B) _____
									_____
									C) _____
									_____
20.	1	2	3	4	5	6	7		A) _____
									_____
									B) _____
									_____
									C) _____
									_____

Instructions for Group Discussion

Review your own answers again and change any if you wish. Then the group should take a half-hour and go through each question to see for which numbers each member "voted." If major differences in voting occur, you should discuss them. Then discuss for another hour: "What are the implications of these answers for how the clinic's education program should be designed and executed?" (that is, your written answers in the right-hand column).

ACTIVITY A: ANALYSIS OF PHOTOGRAPHS TAKEN IN CLINICS

Purpose: 1) To develop observation skills in Clinic Education.
2) To develop an analytical technique based on the major sections of this module: Client, Message, Educational Methods and Materials, Physical Setting and Atmosphere, Personnel, Evaluation, Follow-up in the Community.
3) To present an overview of the various aspects of the module.

Time: 2 hours (approximately)

Instructions:

You will be given a number of pictures. Each is a scene taken from a client education setting somewhere in the world. They are not, in any way, selected to demonstrate a "good" or "bad" program in any country. Rather, they are a "slice of life" and should offer some insights.

We will divide into groups of two people. Each group will be assigned several pictures for close analysis. At the end of twenty minutes each group of two will make a presentation of its observations to the entire group, followed by discussion. You should refer to the "Discussion Guide," below, when you are analyzing the pictures.

The objective of this activity is to develop some insights into client education based on "visual cases" and "actual observation."

In the last half-hour of Activity A, the large group can summarize by developing some "Principles" of Client Education which this activity has illustrated. Participants should call them out and they will be listed on the blackboard by a participant or staff member.

DISCUSSION GUIDE FOR CLINIC PHOTOGRAPH EXERCISE

The framework developed below is rather similar to the structure of the module, that is, (1) Client, (2) Message,

(3) Educational Methods, (4) Clinic Atmosphere, (5) Personnel, (6) Evaluation, (7) Follow-up in the Community. When analyzing and discussing the photographs you should use criteria based on those topics. You should also, of course, add your own criteria.

When discussing the photographs it is suggested that you not merely say "yes" or "no," "good" or bad," but also discuss the "educational implications" of what you see, or don't see. Try to imagine what was happening before the photo was taken and what will happen next, in terms of the client's education.

THE CLIENT:

Facial expression; non-verbal communication; body position; interest in what is occurring in the clinic. What are some words which can be used to describe the clients? Are they accompanied by relatives, husbands, wives, children? Any evidence of long or short wait, or degree of physical comfort? How are they passing the time during the waiting period? Dress characteristics or other things which may indicate client's attitude toward the clinic and staff. Any indication that "learning" is taking place? Are there first-time or "follow-up" clients or both? Are clients asking questions? What relationship does the client seem to have with any staff member in the picture? What communication or relationship (if any) do the clients seem to have with each other? Should they? Do any of these words apply to the client: happy, sad, talkative, worried, smiling, laughing, alert, quiet? What other things about the client can be observed which may give us an idea of how to plan and execute an education program?

THE MESSAGE:

Is it possible to tell or guess what is being said or shown? How long does it seem to take for this message to be given?

METHODS AND MATERIALS:

What educational methods are pictured? Which ones look like they are being done well; which need improvement? What others might be used? Why? Lecture; discussion between clients;

question and answer; interview; use of visual aids; use of audiovisual equipment, printed material, take-home material. Do they seem to be available in adequate quantities? Any evidence of follow-up education/motivation for clients who are in the clinic returning for routine follow-up? Where and when during the clinic visit does it appear that the activity pictured is taking place? Is that the best place and best time for this activity? Why?

THE GENERAL CLINIC ATMOSPHERE AND PHYSICAL ARRANGEMENT OF THE CLINIC:

Seating arrangement: Is it conducive to learning? to clients' talking? Placement of other items: desks, tables. Type of seating: benches, chairs, etc. Does it look quiet, noisy, cold, comfortable, hot, cheerful, drab, etc.

What things seen in the physical environment appear to help the client's education, motivation, and confidence? What appears to hinder it?

PERSONNEL OF THE CLINIC:

Non-verbal communication of the staff, facial expression, body position, eye contact with clients, distance from clients? What category of staff is doing the "education"? Are they the most appropriate for that educational task? What is other staff in the clinic seen doing? What is the staff's apparent relation to the clients? To other staff members? What are some words that might describe the staff? Does the staff look physically as well as mentally comfortable while performing the educational tasks? Do they look like the kind of people clients would trust and believe in?

EVALUATION:

Are any activities pictured which indicate that the education program is being either informally or formally evaluated by the staff? Is there any evidence of pretesting of the educational materials? Is there any evidence that the clients are understanding/accepting or not understanding/accepting what is happening?

FOLLOW-UP AND OUTREACH INTO THE COMMUNITY:

Is there any evidence in the pictures that the clinic is providing some informational or motivational follow-up support to the client once she or he leaves the clinic and goes back to the village? Is there any evidence that an effort is being made to do special follow-up education of clients who are returning for routine follow-up visits?

(The space below is for your notes on Activity A.)

SELF-TEST

Check your own progress by answering the following questions.

1. List at least four characteristics of audiences for clinic education which affect the way the program is designed, and identify the educational implications of each.

Characteristic	Educational Implications

2. List at least four characteristics of the clinic setting and how each affects education in the clinic.

Characteristic	Program Implications

ANSWERS TO THE SELF-TEST ARE ON THE NEXT PAGE

ANSWERS TO SELF-TEST

1. Check your answer against the lists in Exercises 1 and 2.

2. There are many possible answers to this question. Check your answers against the discussion guide in Activity A and against the results of that activity.

Notes and Reactions

UNIT III

THE MESSAGE

UNIT OBJECTIVES

When you have completed this unit, you should be able to:

1. List four steps in message development.

2. Describe three methods for identifying the information/education needs of clients.

3. Explain arguments for and against teaching human anatomy and physiology as part of the clinic education program.

4. Explain why each of the following principles of message design is important, and how a clinic educator can use them in preparing messages:
    - appropriate vocabulary level
    - message repetition
    - message timing

5. List and explain three basic ideas about pretesting a message.

GETTING STARTED WITH YOUR OWN EXPERIENCE

The exercise below is designed to help you begin this unit with your own experience and ideas. Answer the following questions:

1. From your own experience, what are the steps a clinic educator should go through in developing messages? List at least four.

2. How can we find out what things a typical client wants to know about family planning, and what aspects of family planning are most important to him/her?

3. What other things besides "what the client wants to know" should be included in clinic education messages?

4. How many "pieces" of information or "message facts" can a client absorb and learn in the time we have to do clinic education? For how many weeks or months is the client expected to remember that information?

5. Are we presently giving too much, too little, or the right amount or message facts or "pieces" of information? Explain.

6. Is human anatomy and physiology currently taught as part of your clinic education program? Why or why not?

7. Listed below are three principles of message design. For each principle, describe briefly what it means to you, why it may be important, and how you can use each principle in developing clinic education materials.

Principle	What It Means	Why It Is Important	How It Can Be Used
1. Appropriate Vocabulary			
2. Message Repetition			

3. Message Timing

8. Is message pretesting done in your clinics (or for your clinics)? If your answer is yes, list the most important steps that are taken in pretesting.

NOTES FROM THE EXPERIENCE OF OTHERS

You will recall that the goal of clinic education may be thought of as creating a contraceptive user who is:

CONTINUOUS
INFORMED AND CONFIDENT
SATISFIED
VOCAL

It is helpful to keep this goal in mind when developing messages for clinic education. As a general rule, messages which contribute to these goals should be most important. These messages are the ones that will help clinic education attack the problem of high dropout rates.

In discussing message content, we will work within a systematic process for message development. Such a process helps us remember to deal with important aspects of message development--client needs, message content, message design, and message pretesting.

A SYSTEMATIC APPROACH TO MESSAGE DEVELOPMENT

How often do clinic educators develop messages with some idea of the information needs of clients? How often do they know why they use one message instead of another? How often do they have an idea why one message is used more often than another--or why it is presented to clients at a particular time while they are in the clinic?

Unfortunately, the answers to these questions are often "seldom," or even "never." We suggest that by following a few simple steps in message development, clinic educators can design and use messages with increased confidence that they can help achieve educational goals. We see four steps:

- Assess Client Information Needs
- Develop Message Content and Priorities
- Design Messages with
  - -appropriate vocabulary
  - -sufficient repetition
  - -appropriate timing
- Pretest

Another way to think of these steps is What Do Clients Want and Need to Know? What Should Messages Say? How Should It Be Said? How Do We Know If Messages Work? We will discuss each of these steps below.

STEP ONE: ASSESS CLIENT NEEDS

or

What Do Clients Want and Need To Know?

If our messages are to help achieve the goal of clinic education, we must find ways to provide clients with the information they need to be informed, confident, satisfied, and vocal. But how can we find out what these needs are?

Ask the Client!

One way is to ask the client directly. However, many clients will not have thought very much about their information needs. This means that clinic staff need to be specific in asking questions. An example of a form used to identify client information needs is given on the following pages.

There are some interesting features in this form. You will notice that the questions enable a client to be quite specific in identifying information needs. The form also helps the staff get information about the process of their clinic education program (questions 6-10), and integrates family planning with general health issues (question 5). The questionnaire is used after the client has been through the clinic, and also contains a question designed to evaluate the effectiveness of clinic staff (question 11).

By obtaining this information from clients, the clinic staff can find out which information needs are most important for their clients. These priorities are then used to determine which messages should be given the most emphasis within the program.

Of course this form is useful primarily for clients who can read and write. For illiterate client groups, however, a form can be used as the basis for interviews. While it is usually not possible to interview every client in a busy clinic, staff can interview a small group (or "sample") by having a policy to interview every third, or fourth (or fifth!) client. In an interview the staff would probably reduce the number of questions, and would be careful to ask questions which require the client to answer more than "yes" or "no." Questions like these can be useful. Use the spaces provided to add questions of your own.

- *What will you do if bleeding does not stop after seven days after your IUD was inserted?*
- *What will you do if you forget to take two pills in a row?*
- *When your husband asks you if he will be able to feel your IUD, what will you tell him?*
- *What kinds of things can temporarily happen to make you feel uncomfortable on your new method? If they do occur, what will you do?*
- _____
- _____

PLANNED PARENTHOOD FAMILY PLANNING CLINICS

Is this your first visit to a Chicago Planned Parenthood Center?

___ Yes ___ No

Date _____

CLIENT NEEDS ASSESSMENT

To help us better match our services to your personal needs, we ask that you complete the following questionnaire. Please read the questions below and check ( ) the ones you would like more information about.

1. PLANNED PARENTHOOD SERVICES

___ contraceptive services
___ pregnancy testing
___ options to a problem pregnancy
___ teens rap groups
___ volunteer opportunities
___ counseling for individuals and families
___ men's motivation
___ vasectomy information
___ infertility counseling
___ library resources
___ research activities
___ speakers bureau activities

2. PHYSICAL EXAMS: WHAT THEY SHOW

___ Blood test
___ Urine test
___ Breast exam
___ Pelvis exam
___ Blood pressure
___ Pap smear
___ V.D. screening
___ Medical history
___ Weight

3. CONTRACEPTIVES

General

___ Method available
___ How methods are used
___ Methods: Pros & Cons
___ Side effects
___ Complications

Your Selected Method

___ How it is used
___ Effectiveness
___ Combining with other methods
___ Effectiveness over time
___ Side effects
___ Reasons for a return visit

4. WOMEN'S HEALTH

___ Doing a self-breast-exam
___ Preventing vaginal infections
___ Recognizing vaginal infections
___ Treating vaginal infections
___ Info on anatomy, physiology
___ Preventing venereal disease
___ Recognizing venereal disease
___ Treating venereal disease

5. HUMAN SEXUALITY

___ A woman's sexual needs and responses
___ A man's sexual needs and responses
___ Male and female roles and stereotypes
___ Opportunity for private discussion with a Planned Parenthood Counselor

6. I'd like to learn about birth control:

___ in a group session
___ in an individual session
___ doesn't matter
___ don't need further information

7. If there is a group session, I'd like it to be:

___ a "rap" session where I can ask questions and talk about birth control with other women
___ a lecture where I listen to a person tell me about birth control methods
___ doesn't matter

8. I would like a clinic where:

___ someone gives me a chance to talk about my relationship with my boyfriend or my personal feelings about having sex
___ nobody asks me anything about my relationship with my boyfriend or my personal feelings about having sex
___ doesn't matter

9. I'd like to learn more about birth control:

___ on a different day from when I get my exam
___ the same day as my exam, even if it means a longer wait at the clinic
___ doesn't matter
___ don't need further information

10. During the pelvic exam, I'd like the doctor to:

___ explain what he/she is doing during the examination
___ examine me without talking about it
___ doesn't matter

11. How comfortable did you feel talking with:

	VERY	SOMEWHAT	NOT VERY
A. the receptionist			
B. the interviewer			
C. the lab technician			
D. the doctor			
E. the nurse-practitioner			
F. the nurse who gave you your supplies			
G. other staff (who?_____)			

Whether we use a written questionnaire or an interview, it is important to gather information several times during the year (if it cannot be done all the time). Information needs change, and our messages should change as well.

Ask the Staff!

Experienced clinic staff can be a good source of ideas on client information needs. With staff, as with clients, we need to ask good questions if we are to get good answers. Here are some examples. Use the spaces provided to add questions of your own.

- *What questions do clients ask you most often?*
- *What topics do clients feel uncomfortable in talking about?*
- *What topics seem very new to clients?*
- *What topics bore the clients?*
- *What topics do clients seem to be least well-informed on?*
- *What are the rumors about family planning that clients seem most worried about?*
- *What are the differences in questions between new clients and continuing clients?*
- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____

It is often a good idea to compare the information from clients with the information from staff. Topics that appear important to both should have high priority.

Ask the Researcher!

An increasing amount of research on clients is available in many countries. This research, while rarely done specifically for clients,* can still provide useful ideas about client information needs.

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*There are, of course, research studies which deal directly with clinic education. See the References section of this module.

Remember--Clients Are Different!

You will recall from Unit II that different groups of clients have different information needs. Men and women, for example, have different information needs about different contraceptives. We should remember, therefore, to organize our information about client needs for each important audience. To do this, we need the kind of information about clients that we discussed in Unit II--for example, sex, age, income, religion, etc. When we ask staff about client needs, we should ask them to identify which clients they are talking about using the same criteria.

STEP TWO: DEVELOP MESSAGE CONTENT AND PRIORITIES
or
"What Should Messages Say?"

A communicator with extensive experience in family planning, William O. Sweeney, has observed that "messages are all too often what the programmer wishes to say rather than what the intended audience needs and wants to know."* If we begin the process of message development by identifying the information needs of clients we can begin to avoid this problem. Our needs assessment will probably identify the basic areas in which clients need information--areas such as how to use contraceptive methods, reassurance about safety, side effects and what to do if they appear, and that other people like them use contraception.

A problem in deciding on message content is the limited time available for education in the clinic. If, as some experts believe, most clients can learn and remember only about twenty short, separate facts, clinic educators must set some priorities among content areas. In most clinic settings, we cannot provide all of the information that clients may want or need. This is particularly true when we must also include messages that are part of the broad family planning communication program.

Setting message priorities requires the experience and good judgment of the clinic educator. A useful tool in setting these priorities is a checklist. An example of such a checklist is given on pages 73 and 74. The message areas in the checklist are typical of many clinic settings. A checklist like this can be used as the basis for clinic staff discussion of content areas and priority setting.

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* William O. Sweeney, "Communication Activities That Promote Behavior Change in Clients of Family Planning Programs: Resources and Constraints," in Information, Education, and Communication Strategies: Their Role in Promoting Behavior Change in Family and Population Planning, ed. Lyle Saunders (Honolulu: East-West Communication Institute, 1977).

CHECKLIST FOR SETTING MESSAGE PRIORITIES

	VERY IMPORTANT TO INCLUDE	MEDIUM IMPORTANCE		NOT IMPORTANT TO INCLUDE OR NO TIME TO INCLUDE	I'M NOT SURE HOW IMPORTANT THIS IS
1. menstrual cycle	1	2	3	4	5	6
2. how people get pregnant	1	2	3	4	5	6
3. side effects that are possible	1	2	3	4	5	6
4. rumors about effects of contraception which are not true	1	2	3	4	5	6
5. what to do if common side effects occur	1	2	3	4	5	6
6. why family planning is important to the country	1	2	3	4	5	6
7. why family planning is important to the individual family	1	2	3	4	5	6
8. female anatomy—ovaries, Fallopian tubes, etc.	1	2	3	4	5	6
9. what will happen during the pelvic exam	1	2	3	4	5	6
10. when to come back to the clinic	1	2	3	4	5	6
11. when to take last pill	1	2	3	4	5	6
12. how the loop works to prevent pregnancy	1	2	3	4	5	6
13. cancer	1	2	3	4	5	6
14. infant nutrition	1	2	3	4	5	6
15. who else uses the methods	1	2	3	4	5	6
16. time for questions and answers	1	2	3	4	5	6
17. what birth control can do for me	1	2	3	4	5	6
18. sex education	1	2	3	4	5	6
19. reassurance	1	2	3	4	5	6
20. responsible parenthood	1	2	3	4	5	6
21. male anatomy: sperm, testis	1	2	3	4	5	6

	VERY IMPORTANT TO INCLUDE	MEDIUM IMPORTANCE		NOT IMPORTANT TO INCLUDE OR NO TIME TO INCLUDE		I'M NOT SURE HOW IMPORTANT THIS IS
22. happy family life	1	2	3	4	5	6
23.	1	2	3	4	5	6
24.	1	2	3	4	5	6
25.	1	2	3	4	5	6
26.	1	2	3	4	5	6
27.	1	2	3	4	5	6
28.	1	2	3	4	5	6
29.	1	2	3	4	5	6
30.	1	2	3	4	5	6
etc.	1	2	3	4	5	6

Take a few minutes to evaluate the topics on the checklist, and to add topics of your own in the space provided.

Making a checklist like this is often the next step to take after assessing client information needs. The message areas identified from clients, from staff and from research can be listed in this (or a similar) format, rated by staff, and the most important areas selected.

SOMETHING TO THINK ABOUT

In many clinics, around the world, a major content area for messages is "how our bodies work." Human anatomy and physiology of reproduction are often the most important part of the clinic education program. Clients are shown how the egg is released, the fertilization of the egg by the sperm, how the loop and pill come into the picture, and so on.

Many clinic educators feel that this kind of content is not needed. In fact, they argue that there is limited time available for clinic education, and that other kinds of messages are more important. Thus they feel that teaching how bodies work can waste valuable time. Finally, they cite several research studies that show that clients do not think physiology is an important information need. *

Others feel that clients have the right to know how their bodies work. They also feel that knowledge of the body helps clients understand why a certain contraceptive method must be used in the correct way.

Still others feel that this information should be made available for those clients that want it, and that it should be provided when rumors or misinformation regarding anatomy and physiology appear for a group of clients.

What do you think? Take a few minutes to write your ideas on this issue in the space below:

_____

_____

_____

*See the Sweeney article cited earlier in the unit and "Tailoring Information and Education Material To Specific Audiences Is Crucial for Success," which is in the Supplemementary Readings section of this module.

STEP THREE: DESIGN MESSAGES

or

"How Should It Be Said?"

The first two steps of message development--assessing client information needs and determining content priorities--give the clinic educator a good idea of the general kinds of messages that will be most useful in the clinic. These general message areas must then be developed into messages which enable clients to learn as quickly, easily, and permanently as possible. This step in the process of message development is often called "message design."

Message design is the process of deciding how, when, and how often to provide information to clients for a priority content area. Key elements of this design process are vocabulary, timing, and repetition. Each of these is discussed below. A fourth, very important, aspect of messages is the media (or educational methods) used to share them with clients. Media and educational methods will be the topic of the next unit. Here we will discuss issues in message design which apply regardless of the media used.

Vocabulary

Words, whether spoken or written, carry much of the burden of communication. We may use pictures for illiterate clients--but we still discuss what the pictures mean with them. Films, filmstrips, slide-tape shows--all are supported by words. And the importance of words for written materials is obvious.

As we all know from experience, words are not as easy to use as some people think. Words have a way of meaning different things--or nothing--to different people. For clinic educators, this means that we must be careful to use words that

our clients know and use. Medical terms, for example, are usually unfamiliar to rural people, and can get in the way of communication. Dr. Juan Flavier of the Institute for Rural Reconstruction in the Philippines found several years ago that the word often used by family planning workers for sperm (esperma), also means "candle" in Pilipino. A farmer, who did not know that sperm are the male seeds, reacted only half-jokingly by saying, "I swear, Dr. Flavier, that my wife and I put out the candle before we went to bed!"

When words are part of the clinic message, find out how clients talk about the topic of the message. A good way to do this is to have a small group discussion among a number of typical clients, making note of the words they use. Sometimes clinic educators from urban areas find rural clients using words that the educators don't know; sometimes they use words that clinic educators are embarrassed to use! But for effective communication--and learning--educators should use the vocabulary of the client.

What to do if there are no words in the client's vocabulary that can be used --say, for the IUD? In this case, the clinic educator must have messages which teach clients the meaning of the new word. What we must try to do is avoid using words that clients do not know, assuming that their nods and smiles mean that they understand!

Timing

When during the clinic visit is the client most receptive to education?

There are certain important pieces of information that can be given to the client when she/he is most receptive and interested. For instance, most clients want to know what is being done to them and why. When a woman is getting her blood pressure taken, it is a good time to tell her that it is taken to make sure that she does not have high blood pressure, because if she has high blood pressure then she might not want to take the pills. A survey done in the United States* showed that the one piece of information these clients wanted to know was what was happening to them during the pelvic examination. The time they most wanted to know this was while it was happening to them.

Other, less threatening, pieces of information can be given at other times, for instance, in the waiting room.

Clinic staff often complain that they don't have time to do client education and they, of course, don't want to keep the clients at the clinic any longer than necessary. Thus if they can each be responsible for just a piece of the educational

*For further information, contact Jan Brittain-LaBrie, Planned Parenthood Association/Chicago Area, 55 E. Jackson Blvd., Chicago, Illinois 60604.

message that they can give while they are attending to the client, then the time in a group session can be drastically reduced. Also, if pamphlets or audiovisual aids are available to repeat the information given by the staff, then we can be more sure that the clients will remember it.

Repetition

It is a well-established learning principle that repetition helps people remember information or ideas.

How many times in one clinic session are each of your high priority topics repeated? How many times should they be repeated? In order to find out how many times each of your topics are repeated you might like to observe a clinic using forms like those shown on the following pages. Note that there are two forms. One helps the clinic educator identify materials which present messages; the other helps identify people who deliver messages.

You may want to adapt the forms to cover the topics, personnel, and media you have and are interested in. The forms allow space for marking whether staff in specific positions are volunteer or paid. The instructions included here explain how to use the forms and what information you can expect to get from them.

After you find out how many times your chosen topics are presently being repeated or if they are being covered at all, you need to decide what changes need to be made. Do you want to repeat your first priority topics three times during the clinic session using different media or staff? Repeat your second priority topics twice and your third priority topics once? This is a formula that many family planning clinics have found effective.

STEP FOUR: PRETEST
or
"How Do We Know If Messages Work?"

How can one find out if a pamphlet, audiovisual aid, lecture, or other message works--before we put a lot of money and effort into producing or presenting it?

Outside of doing indepth research for every piece of the educational package, a simple pretest is the best answer. * A good pretest does not depend on getting hundreds of people over a long period of time. But it does depend on getting

*For a complete discussion of pretesting, see D. Lawrence Kincaid and Iqbal Qureshi. Pretesting Family Planning Communication, A Professional Development Module. Honolulu: East-West Communication Institute, 1977.

INSTRUCTIONS
CLIENT EDUCATION TOPICS EVALUATION SYSTEM*

These forms are designed to be used by the person in your program who is repsonsible for supervising client education. This system was developed as a way to aid your own evaluation and planning process for your client education programs. It can help you to identify gaps in your coverage of client education topics. There are two charts included to record coverage of topics: One is used to assess available materials; the second is used for personnel.

INSTRUCTIONS FOR FILLING OUT CHART

A "√" should be put in a box when that person or material/medium covers the corresponding topic. On the Personnel form "V" stands for Volunteer and the "S" for Staff. The blank following each one is to put the amount of people who fill this position in a volunteer or staff capacity. You may want to use this code for the rest of the form:

√ = covered in English by designated person or material

√ = covered only sometimes by designated person

√ = covered in English and Spanish by designated person or material

INTERPRETATION OF COMPLETED CHART

A completed form can tell you:

1. which topics are not covered by any material or person.
2. which topics are repeatedly covered and by whom or by what material. (It is considered an effective practice to repeat important topics in different ways.)
3. if one staff member or material is expected to cover too many topics in one clinic session.

---

*Developed by Planned Parenthood Association/Chicago Area

4. (Personnel form only)
   which clinic staff (paid or volunteer) are supposed to be covering a certain topic, but are not. Thus duties may need to be changed, training given, or disciplinary action taken.

This information can help you make decisions and plans regarding:

1. carrying out priorities of topics to be covered in the clinics (e.g., topics that you feel are not as important as others may only need to be offered once in clinic or "sometimes" when a need is presented.
2. the addition or subtraction of topics to be covered.
3. topics to be covered in the future, after appropriate staff are trained or education materials obtained.
4. coping with topics which clients frequently ask questions about. It can help you see who or what material should be used to cover those topics.

PERSONNEL AND CLIENT EDUCATION

TOPICS	PERSONNEL	Receptionist V — S —	Interviewer V — S —	Rap Leader V — S —	Social Worker V — S —	Clinic Aide V — S —	Nurse LPN — RN —	Nurse Practitioner V — S —	Physician V — S —	Charge Nurse LPN — RN — V — S —	Educator V — S —	Lab Technician V — S —	Outreach Worker V — S —	Person Giving Supplies V — S —
INTRODUCTION TO FAMILY PLANNING AGENCY														
Reasons for family planning														
Directions to the clinic														
Transportation systems to the clinic														
Phone no. for general information														
Services offered by family planning agency														
Population information														
Male motivation														
Male education														
Human sexuality														
PROCEDURES AND INTERVIEWS														
Clinic procedures														
Client comfort														
Confidentiality														
Clinic fee														
Client rights														
CONTRACEPTIVE INFORMATION														
Contraceptive method use														
Contraceptive effectiveness														
Contraceptive complications														
Dispel contraceptive myths														
Latest contraceptive research														
Reproductive anatomy														
Importance of individual choice of method														
In-depth explanation of method chosen														
RELATED MEDICAL INFORMATION														
Venereal disease														
Vaginal infections														
Self-breast examination														
PAP smear														
FOLLOW-UP/REFERRAL SERVICE														
Importance of return check-up														
Addresses of other family planning clinics														
Phone no. to call if problems														
Medical referrals														
Referrals to social service agencies														
Other:														

CLIENT EDUCATION MATERIALS

TOPICS / MEDIUM	Pamphlet	Poster	Flip Chart	Teaching Model NAME/TYPE	Film TITLE:	TITLE:	TITLE:	Other:	
INTRODUCTION TO FAMILY PLANNING AGENCY									
Reasons for family planning									
Directions to the clinic									
Transportation systems to the clinic									
Phone no. for general information									
Services offered by family planning agency									
Population information									
Male motivation									
Male education									
Human sexuality									
PROCEDURES AND INTERVIEWS									
Clinic procedures									
Client comfort									
Confidentiality									
Clinic fee									
Client rights									
CONTRACEPTIVE INFORMATION									
Contraceptive method use									
Contraceptive effectiveness									
Contraceptive complications									
Dispel contraceptive myths									
Latest contraceptive research									
Reproductive anatomy									
Importance of individual choice of method									
In-depth explanation of method chosen									
RELATED MEDICAL INFORMATION									
Venereal disease									
Vaginal infections									
Self-breast examination									
PAP smear									
FOLLOW-UP/REFERRAL SERVICE									
Importance of return check-up									
Addresses of other family planning clinics									
Phone no. to call if problems									
Medical referrals									
Referrals to social service agencies									
Other									

a good sample of clients. The most commonly used pretest design is to take a random sample of clients in cycle of clinic sessions. This means if clinic sessions are held Monday, Wednesday, and Friday, a random sampling should be done at each. There should be a sampling done at each clinic session that is at a different time of day because clients who come to the morning clinic may be different from those who come in the evening.

It is important to use your own good judgment on the extent to which you do the pretest. For example, you might pretest the copy for a pamphlet this way: Have a client read the whole pamphlet, circle the words unfamiliar to her, and write her comments to a few questions designed to test her understanding. You may only need to randomly choose ten to twenty clients. If you want to pretest a new symbol, you may want to test it on your clients plus the types of people who you feel may be potential clients to see what it means to each of them. Thinking of your situation at the clinics you are associated with, how would you carry out a pretest of a poster on birth control methods?

Another important part of pretesting is the questions you ask and how you ask them. For instance, we often see people test materials, such as a film, by asking, "Are there any questions?" People rarely respond to this abstract type of question. Questions need to be specific.

"Which point is most important to you?"

"Which point is least important to you?"

"What does this symbol or word mean to you?"

"What order do you think these topics should be in?"

"Which of these three pamphlets would you give to your friend?"

Pretesting does not have to be complicated. The three important points to remember are:

1. DIFFERENT GROUPS
   You want to remember that clients groups are different, and to be sure to test the material with the group or groups for which the message is intended.

2. RANDOM SELECTION
   You want to select individuals for the pretest in a random way. This means, for a particular group, that you select individuals from the group in such a way that everyone in the group has an equal chance of being chosen.

3. GOOD QUESTIONS
   You want to find out if a message means the same thing to a

client that it means to you, the clinic educator. Thus you want to find out if they understand the words, the pictures, the order in which the information is presented--and other such basic but important things.

Sometimes pretesting can seem like a bother--but it can help us avoid mistakes, and increase the effectiveness of our messages.

UNIT SUMMARY

1. There are four main steps in message development:
   - Assess Client Information Needs
   - Develop Message Content and Priorities
   - Design Messages With
     - -appropriate vocabulary
     - -sufficient repetition
     - -appropriate timing
   - Pretest
2. We can assess client information needs by asking the client, the staff, or existing research.
3. Because of limited time, clinic educators cannot provide all possible information on family planning; therefore we must set message priorities.
4. Clients can probably only remember about twenty short, separate pieces of information.
5. Whether or not to teach anatomy and physiology as part of the clinic education is a point of disagreement among experienced clinic educators.
6. In designing messages, it is important to use words that clients know.
7. Information can be given to clients at various times during the clinic visit. In deciding when to present information, the clinic educator should take into consideration the nature of the information and how it might be given most naturally during the clinic visit.
8. Messages should be repeated to insure learning. Most important messages should be repeated most often.
9. Pretesting messages in advance can help us find out if they work, provided we remember to test with the clients' groups for whom the message is designed, select individuals for the test randomly, and ask good questions.

SOMETHING TO DO

The activity below has been provided to stimulate more thinking on the ideas in this unit. It can serve as the basis for discussion sessions when the module is being used by groups.

ACTIVITY B: DEFINING THE MESSAGE (AND CREATION OF EDUCATIONAL MATERIALS)

Purposes: Primary purpose of this Activity: To decide on what should be the message (the "content") of the clinic education. WHAT EXACTLY, SHOULD THE WOMAN LEARN WHEN SHE IS IN THE CLINIC. For this reason Step Number 2 below is the most important part of Activity B.

Secondary purpose of this Activity: To rapidly go through the entire process of creating an educational material for use in the clinic.

The steps are:

1) Define the Audience (Unit II)
   Develop the Message by
2) Assessing Client Information Needs
3) DEVELOP MESSAGE CONTENT AND PRIORITIES
4) DESIGN MESSAGE
5) Create Prototype
6) Pretest the Prototype

Time: 2 hours

Step I: Defining the audience--(in terms of those characteristics that will affect the way we design our clinic education program) Let us say, therefore, that we have defined our typical client as:

1) A woman
2) Already inside our family planning clinic (so already somewhat motivated)
3) Here for the first time seeking family planning services (rather than for a follow-up visit)
4) Illiterate (so that we cannot give her a written leaflet to read in the clinic and expect some of our education work to be done)

5) Has little schooling (so not accustomed to learning things quickly by lecture or demonstration)

Step 2: Assessing Client Information Needs: Let us say that we have found that the typical client is worried about how the method will affect her health.

Step 3: DEVELOP MESSAGE CONTENT AND PRIORITIES: In this step we create the "specific content" of the message. THIS IS THE MOST IMPORTANT STEP IN THIS EXERCISE. Let's assume that the clinic emphasizes the IUD so that message information should be about the IUD, rather than Pill, etc. Let's also assume that the educational "medium" or material we are creating is going to be a short lecture, accompanied by an illustrated flipchart.

Exercise: At this point the Activity leader should ask the participants to take fifteen minutes and write down in the space below all the items of information which the woman should learn. These should be listed in short phrases which are understandable to the woman. For example, instead of listing "it's reversible," you should write, "You can have babies again when you want."

In this exercise it is very important to keep the number of messages to a basic minimum, in order to avoid confusing the client with unnecessary information, and so that these "most important" messages can be learned very well. We have given two examples:

1) "You can have babies again when you want."
2) "The pleasure of sexual relations will not be changed for you or your partner. Neither one can feel the IUD."

PARTICIPANTS SHOULD FILL IN THE BLANK SPACES BELOW

3) _____

_____

4) _____

_____

5) _____

_____

6) _____

_____

7) _____

_____

8) _____

_____

9) _____

_____

10) _____

_____

11) _____

_____

12) _____

_____

13) _____

_____

14) _____

_____

Discussion by the group of those items listed above. (Discussion to last about one hour.)

After fifteen minutes of making the above list, the Activity leader asks participants to call out items from their lists, and he writes them on the blackboard. He should write them in short phrases, understandable to village women, if they are not called out in that form.

If some participants do not agree that some of the items being listed are important to include, they should say so and briefly explain their disagreement.

When this exercise is being done, there are usually about twenty items listed on the blackboard. After all are listed, the Activity leader asks the group to decide how many total "items" the typical woman can be expected to "learn" (and remember) during the fifteen-twenty minutes, which is the usual length of a clinic educational session. Many participants have felt that twenty message items is too many. Do you agree?

The group then decides (discusses, then votes) on which items from the blackboard are "Most Important" and which ones must be eliminated in order to simplify the message.* (THIS DISCUSSION, OF MESSAGE ITEMS, IS THE PART OF THIS EXERCISE WHICH IS OF GREATEST IMPORTANCE.)

How to find out for sure what items are important?

After the above discussion is over, another question should be raised, and discussed by the group for ten minutes: How can we learn what really are the things that the village woman is concerned about knowing, and needs to know, in order to prevent her from becoming a dropout.

*The Appendix, "A List of Message Items for (IUD) Clients in the Family Planning Clinic," was developed at prior workshops. After you have made your own list, you may wish to compare lists.

1) _____

_____

2) _____

_____

3) _____

_____

4) _____

_____

SELF-TEST

Check your own progress by answering the following questions.

1. List the four steps in message development.

2. Describe three methods for identifying the information needs of clients.

3. Explain the arguments for and against teaching anatomy and physiology as part of the clinic education program.

4. Explain why each of the following principles of message design is important, and how a clinic educator can use them in preparing messages.

Principle	Why It Is Important	How It Can Be Used
Appropriate Vocabulary		
Message Repetition		
Message Timing		

5. List and explain three basic ideas in pretesting a message.

ANSWERS TO THE SELF TEST ARE ON THE NEXT PAGE

ANSWERS TO SELF-TEST

1. Assess Client Information Needs
   Develop Message Content and Priorities
   Design Messages With
   - -appropriate vocabulary
   - -message repetition
   - -message timing

   Pretest

2. Obtain information from 1) clients, 2) staff, and 3) research.

3. For: Clients have a right to know how their bodies work; knowledge of how the body works help clients understand how to use a contraceptive method; this knowledge can help prevent rumors.

   Against: Clients don't need or want this information; there are more important messages, and these should have priority in the limited time available for clinic education.

4.

	Why It Is Important	How It Can Be Used
Vocabulary	Messages must use words that clients understand; clients and clinic educators may use different words.	Find out the words that clients normally use to discuss the message area.
Message Repetition	Messages must be repeated to enable clients to remember.	Repeat priority messages several times during the clinic visit, and in different ways.
Message Timing	There are points during the clinic visit when the client is more ready to receive certain kinds of messages.	Plan to provide information at the appropriate points in the clinic visit.

5. 1) Pretest with client groups for whom the message is intended.
   2) Select individuals for the test randomly.
   3) Ask good questions.

Notes and Reactions

UNIT IV

METHODS AND MEDIA

UNIT OBJECTIVES

When you have completed this unit, you should be able to:

1. Identify at least three conditions in clinics that affect the use of different methods or media.

2. Given an educational method or medium, use references provided to identify characteristics of the medium or method, including limitations.

3. List two advantages of cassette tape recorders for in-clinic use.

GETTING STARTED WITH YOUR OWN EXPERIENCE

The exercise below is designed to help you begin this unit with your own experience and ideas. Answer the following questions:

1. If we want clients to be able both to remember what they learned in the clinic, and to explain what they learned to others, what are some of the methods we can use in our clinic education program?

2. The clinic waiting room is often thought to be an ideal place to do clinic education. What kinds of educational methods are used in the waiting rooms of your clinics?

3. In our experience, the choice of methods and materials to be used often depends on the conditions in the clinic. What are some of the conditions in your clinic that affect the kinds of methods and materials you can use?

4. In your experience, are women clients nervous while waiting in the clinic? Why, or why not? If they are nervous, what can be done about it?

5. What are the different places in the clinic where education can take place? What different staff can be involved?

6. What role can audiovisual aids play in the clinic? Printed materials?

NOTES FROM THE EXPERIENCE OF OTHERS

Here are some basic ideas about educational materials and media for clinic programs. Some of these ideas are presented as questions to help you draw on your own experience.

We must teach things well enough so that the client not only remembers them months later, but knows them so well that she or he can explain them to others. "Remember" and "explain" are two different skills. The latter is considerably harder; it requires intensive teaching efforts in the clinic.

Some implications of the above statements are:

- Teach fewer things and teach them better.
- Teach only what the client needs, not what some "educators" may think she or he needs.
- Repeat the same things many times in the clinic.
- Repeat the same, simple messages in many ways: posters, comments by various staff, talks, tape players, booklets.
- Tell the client why certain things are being taught ("So you won't be disturbed if you hear some rumors, or get some side effects." "So you can explain to your husband, mother-in-law.").

Clients wait for long periods in the waiting areas. These waiting periods are one of the best times to do education of various kinds.

Clients presently hear conflicting information from different staff members. This is confusing to clients. A standard set of messages should be agreed upon, and presented in a variety of ways as the client passes through the clinic.

A basic concept in learning is that the learner should actually practice any skill being taught. If we expect clients to be able to talk to their relatives about family planning, they should practice doing that in the clinic.

Clients will learn more if they are encouraged to ask questions; if the material is presented in an interesting, even entertaining way; if distractions are minimized; if their anxiety can be decreased; if the things learned at the clinic can be reinforced when they return home.

Given space and personnel shortages, it is not practical to direct separate educational messages to the two kinds of clients usually found in the waiting room: the first-time clients and the returning follow-up clients. In fact, their learning needs are quite similar. Therefore the message should be designed for both.

An audio tape player, when used in creative ways, can revolutionize education in the clinics.

A good educational planning tool is the "list" of messages that the client will receive during the time she is in the clinic. As we discussed in Unit III, there is an important use for this list. Educators can take each specific message item and decide in what places, and by what means, each item will be presented to the client.

By observing the few "very best" educators in the country program, it is possible to develop certain educational approaches that work well and which can be "standardized" for all clinic personnel.

Illiterate clients should each receive and take home a simple, completely illustrated booklet with the basic information covered in the clinic.

DIFFICULT CLINIC CONDITIONS

Before discussing more on methods, however, let's look at some of the conditions in clinics which our "methods" have to overcome. Let's call them clinic "conditions" which create difficulty (as distinguished from problems with the "message," the "client," etc.).

What stands in the way? Each country, each program, each clinic has problems. Some are universal; some are peculiar to the particular situation. Creating a list of these and sharing them may add some insights.

What are some of these difficult conditions?

We have listed a few; you may or may not agree. Indicate "yes" or "no" next to each one and discuss these and others with your group.

What are the underlying causes of these conditions? What are some ways that new or different methods can overcome them? Do not spend more than ten to fifteen minutes on this question, since these "problems" can be discussed endlessly, and we must move on to other questions.

Conditions	Some causes of this problem and ways to overcome it
1) Lack of space to do education.	
2) Too little time to do education.	
3) Noisy clinics.	
4) Personnel not trained specifically in client education.	
5) Personnel not very interested in doing client education.	
6) Staff has too many statistics to gather.	
7) Too few personnel.	
8) Lack of useful educational material.	
9) Staff has unclear definition of responsibility for education.	
10) Staff doesn't use existing educational material.	
11) Too many clients at one time to adequately teach in an educational group.	
12) Children distract parents.	
13) Can't darken room to show slides or movies (if available).	

14) Staff gets bored saying the same lecture over and over again.

15)

16)

17)

18)

19)

20)

A Very Special Condition: The Nervous Client

Some clinic educators have reported that many clients who are waiting in the clinic for the first time are too nervous or frightened to learn anything from a talk or demonstration. These educators state that the client's worry is caused by fear of what will happen to them in the medical examination room, etc. As you know, in most all clinics if an educational talk is given, it is done before the examination.

Is this true in your experience: Clients are often too nervous to be learning very much? Check one: (Yes) (No) (Not sure). What evidence do you have to say "Yes," "No"?

_____

_____

_____

If you are not sure if this "nervousness" or "anxiety" is an important factor, how can you find out?

_____

_____

If you feel that "Yes, the client is too nervous," what might be done? Are there practical alternatives? Please add to this list of possible solutions:

1) Utilize various means to decrease anxiety among those waiting, before giving any kind of lecture/demonstration. (Make a list of ways.)

_____

_____

_____

2) Don't attempt to "teach" before the medical examination, but rather devise ways to do it afterwards. (Make a list of ways.)

_____

_____

_____

3) Don't worry about the problem on the first visit--but instead schedule the client to come back relatively soon for a follow-up visit. Thus she or he will be exposed to the same educational efforts while waiting, but this time without the fear of the unknown physical examination.

4)

5)

What are some of the reasons that most clients do not ask any questions of the staff? Should they ask questions? Why? Does the typical clinic staff feel clients should ask them a lot of questions? Why? What can be done?

_____

_____

_____

EDUCATIONAL MATERIALS AND METHODS

Choosing methods and materials for different educational purposes can be a complicated problem. Fortunately for us, the problem has been studied extensively by others. We can benefit from what they have found out. But their experience, like all experience, must be evaluated in terms of your own situation. We are going to ask you to take a look at some things written by others, but before you do, think about the questions below, and write down brief answers.

1. What audiovisual or printed materials have you found to be most useful in client or follow-up education? Why? How have they been used?

2. What are the relative advantages and disadvantages of using the more "professionally" made materials that come from a central (capital city) source as opposed to ones made partly or wholly by local clinic staff?

3. Some clinics report that the educational personnel do not use educational materials that have been provided. Why? What can be done? Some possible factors: (please add to the list) materials not relevant, staff not trained in use, staff not motivated, "too much bother," etc. _____

_____

What can be done? _____

_____

_____

_____

Something To Read

Read the following items in the Supplementary Readings section of this module, then complete this unit.

Gerald Winfield, "Communication Factors in Family Planning: Channels and Media."

Sigrid Deeds, A Guidebook for Family Planning Education.

Tape recorders: A Potentially Powerful Medium

In this Module we are emphasizing the use of an inexpensive audio cassette tape recorder as a way to solve many of the educational problems in the clinic. It can also be combined (keyed) with visuals. For example, a tape player may read or "comment on" the pages of a flipchart or a series of posters on the wall or an illustrated booklet.

This tape player can utilize materials that are made at a central source as well as at the local clinic. It can involve local personnel in production, can relieve the boredom of those personnel who must give the same talk again and again. Tapes can also be combined with music, etc., to be made in ways interesting and novel to the waiting clients . A fresh and interested voice on the tape never loses its freshness, nor does it get bored, tired, or "too busy to give a talk."

In the space below please list other advantages to the use of a tape recorder combined with visuals. Afterwards, list problems you see with the use of such an educational method, and ways such problems may be solved.

Advantages: _____

_____

_____

_____

_____

_____

Problems and Solutions: _____

_____

_____

_____

_____

_____

A METHOD USING REPETITION, THE SAME ILLUSTRATIONS, AND TAKE-HOME BOOKLET

Repetition is crucial to learning. The same, few, simple illustrated messages should be repeated over and over again during all the time the client is in the clinic. This can be done by a variety of ways by the clinic educator, while she is pointing to a flipchart. When the educator leaves the room, it can be done by a cassette tape player which refers to the same flipchart pictures in poster form which are placed, one next to the other, around the clinic walls, or to the flipchart, or to illustrated booklets. If no cassette player is available, any literate person in the room, auxiliary nurse or a waiting client can read the words out loud on the illustrated posters, etc. Even the clinic's illiterate janitor or cleaning lady can memorize and "read" the items out loud. About 12 to 15 illustrations should be used. An illustrated booklet, given to each woman, can also contain the message. The booklet is read to her by someone, or a cassette tape recorder, while she looks at the related pictures.

When clients go home they should be given illustrated booklets with the very same pictures that were explained in the clinic. Because they have memorized the meaning of the pictures, they can use the booklets for several important purposes: The booklets can help them remember the message; they can also help the client explain things to his or her spouse, friends, or, in the case of a woman client, her mother-in-law. The booklet acts as a "legitimizer." That is, it is something printed that the client understands and can use to legitimize his or her decision to practice family planning to him/herself and to others.

The main concept is that clients learn the message so well in the clinic that they can then remember it when they are at home. Equally important, they have the same illustrated message in a booklet. They learned to use ("read") the booklet in the clinic. Once at home they can use it for three main goals: (1) self-reassurance, (2) support in explaining to an inquisitive spouse and relatives, and (3) recruiting other acceptors.

Because the client can have the opportunity to hear and see the basic message four or five times while waiting in the clinic, she can easily remember the message that accompanies each particular drawing. In addition, it is possible to print the written message at the bottom of the pictures, to add credibility to the booklet and so a literate person can also read it, thus adding more credibility.

The following is an example of what we mean by "a series of simple drawings to illustrate and remind illiterate clients of the basic message."

MESSAGE	DRAWING
1) "Couples can have babies again when they want, like this couple who decided to have a new baby."	1) Couple with woman holding a newborn baby.
2) "Wearing an IUD is like wearing a new pair of shoes (or an earring). When they are new they may feel uncomfortable but soon the body adjusts. In the same way the (my) uterus needs two or three months to get accustomed to the IUD."	2) A drawing of a pair of shoes or woman's head with large earrings.
3) "If the IUD causes pain or discomfort take aspirins. They will help you."	3) Picture of aspirin bottle or popular local pain remedy.
4) "The IUD does not interfere with sexual happiness. In fact sexual pleasure of both, husband and wife may be increased when the fear of unwanted pregnancy is removed."	4) A couple holding hands.
5) "The IUD stays in the uterus. It cannot travel to other parts of the body."	5) Outline of woman's body with loop in the pelvic area.
6) "The IUD is safe. Our country's best doctors suggest its use."	6) Drawing of a doctor in "uniform," stethoscope, etc., holding a loop.
7) "The IUD is popular, thousands of women are successfully using it."	7) Drawing of many women.

UNIT SUMMARY

1. Clinic education must teach clients so that they both remember what they have learned, and can explain what they learn to others.

2. Clinic staff should agree upon a standard set of messages to avoid giving conflicting information.

3. An important step in planning for methods and media is to identify conditions in the clinic which can create difficulties for the use of various methods or media.

4. A special condition in the clinic may be the degree to which a client is too nervous while waiting for a physical examination to benefit from educational efforts.

5. Inexpensive cassette tape recorders offer a number of special advantages for clinic education. They can deliver routine messages again and again without getting bored--or boring; they can be used in combination with visuals; the tapes are easy to make right in the clinic; and so on.

6. A variety of methods and media (staff talks, visuals, pamphlets, tape recordings, posters) should be combined in order to repeat important messages throughout the clinic.

7. In learning skills (such as how to correctly take the pill), clients practice the skill with the guidance of staff.

SOMETHING TO DO

The activity below has been provided to stimulate more thinking on the ideas in this unit. It can serve as the basis for discussion sessions when the module is being used by groups.

ACTIVITY C: CLINIC EDUCATION MATERIALS AND METHODS

Activity: A DEMONSTRATION AND DISPLAY OF EXISTING EDUCATIONAL MATERIALS AND METHODS.

Purposes:
1) To familiarize participants with existing materials from various countries for either direct use in participant's country or use after some cultural adaptation.
2) Ways to adapt materials.
3) Utilization of materials in new and different ways.
4) Ways of getting clinic personnel to actually use the materials.
5) Ways to involve clinic personnel in some aspects of materials production.

There will be a demonstration of the use of inexpensive cassette tape players and combination of tape players with various kinds of visuals or booklets.

Emphasis in this Activity is placed on ways that materials can help, or even "replace" the person in the clinic who is supposed to do the education. This is because that person is, unfortunately, often too busy, too tired, poorly trained or sometimes not there at all.

Time: 2 1/2 hours

SUMMARY OF ACTIVITY D

Based on our previous work in clinics it has been found that: (1) the "basic information" of clinic education is really very simple, consisting of about 15-20 items (see Appendix A); (2) this basic

information must be repeated several times so that the clients are sure to retain it. For these two reasons we find that this basic information can and should be provided by an audiotape cassette recorder which is played several times during the client's long waiting period. The voice on tape can refer to a series of pictures for better clarification. Unlike human educators, the tape machine never gets tired or bored, saying the same thing over and over again, and always stays cheerful. The human educators should spend time doing those tasks which only a human can do: answering questions, providing specific information, etc. Humans should not spend their time acting like a machine, i.e., saying the same fifteen or twenty facts over and over. A tape player with some visuals does this job very well.

CLIENT EDUCATION MATERIALS SUGGESTED FOR THE DEMONSTRATION

The approaches and materials listed here for use in the demonstration were selected for three main reasons: They all have the following characteristics, which we think are important for clinic education:

I. THEY AVOID THE ANATOMICAL-PHYSIOLOGICAL APPROACH. INSTEAD THEY STRESS THE CLIENTS' REAL-LIFE CONCERNS (SEE APPENDIX A OF THIS MODULE).

II. THEY ARE DESIGNED TO BE "AUTOMATED" TO SOME DEGREE, TO SAVE STAFF TIME AND STAFF TRAINING.

III. THEY ARE USUALLY AVAILABLE AND RELATIVELY INEXPENSIVE. (ALL MATERIALS, AND PLACES WHERE THEY CAN BE OBTAINED ARE LISTED BELOW.)

(Please note that the materials can be used in many different ways, we are listing only some of those ways.)

A. To demonstrate the concept of an illustrated flipchart or picture series with "script," or topics, written on the back of each page:
(Even though the majority of the flipchart pages are made in a central office, one or more should be made locally so that local personnel feel involved in, and will therefore be more likely to utilize the materials.)

1) Client Education Flipchart. Artwork illustrations are from Latin America, about 15" x 11". Produced by the Health Education Branch of the International Section of the U.S. Department of Health, Education and Welfare. Distributor: Room 214 RPE, USAID, Department of State, Washington, D.C. 20523

2) Motivational Flash Cards (twelve) 11" x 15" line drawings. $3.00. From IPPF, Southeast Asia and Oceania Region (SEAOR), 246 Jalan Ampang, Kuala Lumpur, Malaysia

3) Population Council/Disney Kit and Flipchart. Usually available in offices of National Family Planning Boards, Population Council, Ford Foundation, USAID

4) Flipchart produced by Planned Parenthood--World Population, 810 Seventh Avenue, New York, New York 10019. $12.50

B. To demonstrate the concept of an illustrated flipchart with the "script" provided by a cassette tape player. (Voices of local clinic personnel should always be included in at least part of the tape for reasons described above.)

1) Population Council/Disney Kit. Cassette tape made by recording sound track from the movie in local language or recorded by clinic personnel.

C. To demonstrate the use of a cassette tape player used by itself. (With simple techniques to increase the sound for noisy clinics and to save battery life if no electricity is available.)

1) Client Education tapes, narrated by Dr. Ronald Pion. Kapiolani Hospital, Honolulu. Available from Pfarrago Information Systems, 4760 22nd Avenue N.E., Seattle, Washington 98104

2) Adaptations of above tapes for Latin culture and Spanish language by Rivka Danziger, University of Hawaii, School of Public Health

3) Educational tapes produced by Dr. Royal Colle, Department of Communication Arts, Cornell University, Ithaca, New York

4) "Audio-magazine" cassette tape with music and information spots, produced by Planned Parenthood Association/Chicago Area, Jan Brittain-LaBrie, Dir. Client Education, 55 E. Jackson Blvd., Chicago, Illinois

D. To demonstrate the concept of a sequential series of illustrated posters on the clinic wall which are "read," or each one "narrated," one after the other, by a tape recorder (or read out loud by clinic staff or a literate client).

1) IPPF Poster Series (12 posters) made in Africa. Strong and Healthy Mothers and Children. U.S. $0.65 for series. From IPPF. 18-20 Lower Regent Street, London SW1Y 4PW, U.K.

2) IPPF, SEAOR: Flash Cards see (A) above. U.S. $3.00

E. To demonstrate the use of well-made slides or filmstrip: a) combined with a cassette tape b) combined with a written script c) combined with a take-home pamphlet with the same pictures. (Demonstration of use of rear screen to allow slide and filmstrip projection even in a brightly-lit waiting room.)

1) The Loop

2) The Pill

3) Choice Not Chance

All of the above are made by the World Neighbors Organization. There are several special, separate versions made in the Philippines, India, and Africa. World Neighbors, 5116 N. Portland Avenue, Oklahoma City, Oklahoma 73112 U.S.A. $5.50 per color filmstrip or slide set of 45 pictures.

F. Demonstration of the use of a combination of media, all of which have the same pictures to reinforce it at various times.

1) Posters for walls.

2) Flipchart or filmstrip for clinic "talk"

3) Cassette tape for more interest and saving staff time

4) "Take-home booklet" with message identical to the one presented at the clinic

5) Slides/filmstrip/cassette tape/posters for showing in villages in order to reinforce the users' decision to continue using the method

Example 1: Population Council/Disney Kit

Example 2: OMNI Education Div., Ortho Pharmaceutical Co., P. O. Box 868, Newark, New Jersey 07101 developed this series of educational aids all on the breast self-examination:

1) POCKET CINEMA, a pamphlet that shows a woman doing the exam
2) A model of the breast so client can feel what lumps feel like while they are practicing the correct breast self-examination
3) A hand projector that the individual client can use to see how the doctor shows a woman how to do the breast self-examination
4) A plastic book with three-dimensional pages so client can see what puckering and other symptoms of breast cancer look like. In addition it has a question and answer part where the client can press a box to see if she has the correct answer
5) Sound, color film, 16mm, "Breast Self-Examination"
6) Poster put out by American Cancer Society compliments OMNI's materials.

NOTE: There is very little reading with these materials thus, they are very good for illiterates.

Other client education materials are available. We have selected those described above because they generally illustrate the three concepts we described at the beginning of the activity. IPPF in London publishes lists of available materials. The East-West Communication Institute has a collection of materials, as does the University of North Carolina.

SELF-TEST

Check your own progress by answering the following questions:

1. Identify at least three conditions in clinics which affect the use of different methods or media.

2. Listed below are two educational methods and two educational media. Using the readings assigned in this unit (Winfield, Deeds), identify the advantages and limitations of each. Also put in your own ideas.

	ADVANTAGES	LIMITATIONS
METHODS		
Instruction by Staff while Giving Services		
Speech or Lecture		
MEDIA		
Flip Books		
Videotape		

3. List two advantages of cassette recorders for in-clinic use.

ANSWERS TO THE SELF-TEST ARE ON THE NEXT PAGE

ANSWERS TO SELF-TEST

Note. Your answers may not be exactly the same as those suggested below.

1. Lack of space, noise, uninterested staff, too little time, lack of material, cannot darken room for films or slides, etc.

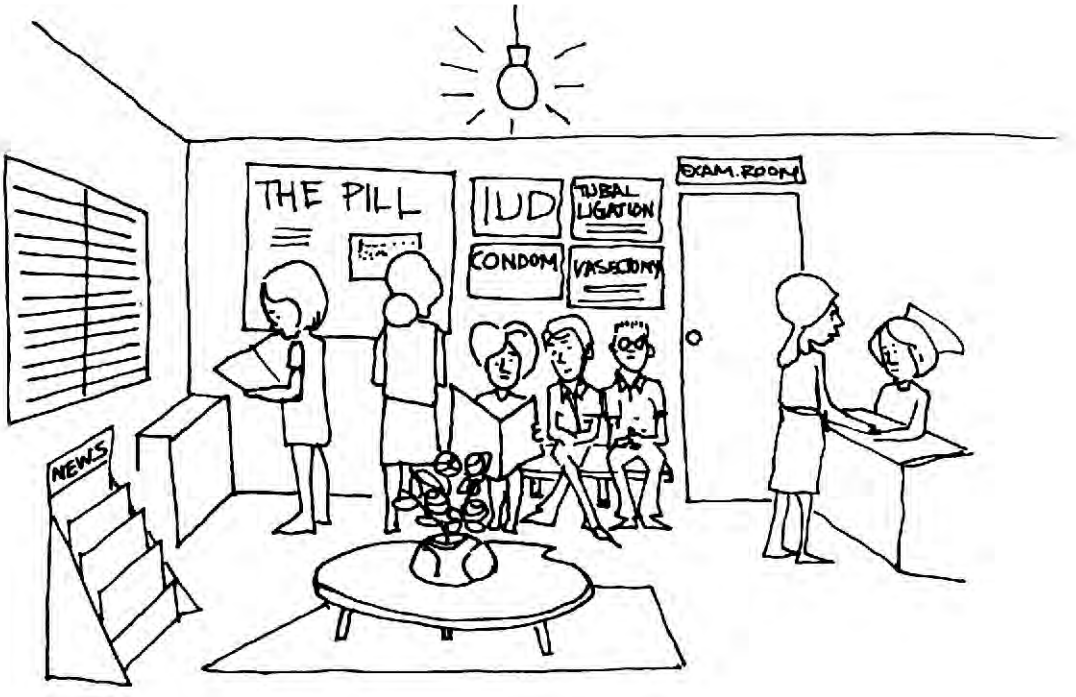
2.	ADVANTAGES	LIMITATIONS
METHODS		
Instruction By Staff while Giving Services (Winfield)	This method can be personal and highly effective for reassuring and motivating clients.	Clients must be in the clinic; staff must be well-trained.
Speech or Lecture (Deeds)	To give basic information. Low-cost (except for staff time). Familiar method to many.	Usually low interest from learner. Hard to repeat many times a day. Does not lead to much audience participation.
MEDIA		
Flip Books	Present information with pictures. Can remind staff of basic points to make. Permits learner to ask questions during discussion. Relatively low cost.	More costly than talking or simple charts.
Videotape	Present information with drama, color, movement. High interest level. Never gets tired.	High cost. Requires electricity and equipment maintenance.

3. Never gets tired repeating messages, can be used with music and other effects to create interest, relatively low cost, tapes can be made in the clinic, etc.

Notes and Reactions

UNIT V

CLINIC SETTING AND ATMOSPHERE



UNIT OBJECTIVES

When you have completed this unit, you should be able to:

1. Write at least one reason why the atmosphere and physical setting of the clinic is an important part of clinic education.

2. List and explain at least three things that can be done to adjust the clinic setting to make it more pleasant and receptive to family planning clients.

GETTING STARTED WITH YOUR OWN EXPERIENCE

The exercise below is designed to help you begin this unit with your own experience and ideas. Answer the following questions:

1. Why is clinic atmosphere and setting important in clinic education?

2. Some people have said that the most important "message" or "communication" that an acceptor ever receives is the way she or he is "received" or "treated" at the clinic. Do you agree? Why or why not?

3. What are ways to find out what is the client's view of the clinic? (Of course this doesn't mean every client's view, but rather ways to occasionally get a sample of views.)

4. Why, specifically, is it important that the client have a favorable view of the clinic, in terms of getting new acceptors as well as continuation rates? The question is asked in this way because administrators may not necessarily be interested in "client's views," but as good administrators, they are interested in acceptor rates and continuation rates.

5. What things can be done to improve the client's view of the clinic?

NOTES FROM THE EXPERIENCE OF OTHERS

THE CLINIC AS THE MESSAGE

Many people have observed that the most important "message" a family planning client ever receives is the way she is received and treated at the clinic. Many clients come from far distances and really make a great effort to visit family planning centers. They suffer a big letdown when they have to wait long hours in the clinic and are received and treated in a cold, impersonal, business-like manner by the clinic staff.

Many clinic personnel ask, "Isn't providing what is obviously a wanted and necessary service enough?" Most personnel claim that because they are very busy it is impossible to give to every woman or man who comes to the clinic the kind of attention such clients need.

The delivery of service is important; but dealing with clients in a business-like, impersonal manner is hardly helpful to any family planning effort. In fact, a cold and unfriendly clinic atmosphere can make clients unwilling to ask questions, unwilling to refer others to the clinic, or reluctant to return. In short, a poor atmosphere can lose clients and increase dropouts!

It may be a little difficult to "adjust" or "control" the staff so that they are more sensitive to clients and their needs. But it is quite easy to adjust the physical setting and provide a warm, pleasant, receptive clinic atmosphere for the client.

The staff members, being human, may not always be cheery. But brightly painted walls, touched up with large, colorful posters are always cheery--every day.

Seating arrangements can help, too. If the staff is too busy to interact with waiting clients, the latter can interact among themselves. Placing chairs in a circle or around small tables can promote talking among clients. Discussions among clients can be an educational experience when acceptors share notes and reinforce each other in continuing on with their chosen contraceptive methods. This will eliminate the sight of bored clients idling away their time while waiting to be served.

THREE IMPORTANT--AND BASIC--THINGS THAT CAN IMPROVE CLINIC SETTING

In summary, there are at least three things that clinic educators can do to make the clinic setting and atmosphere supportive of the education program--and of the clients! They are:

- Brightly painted clinic walls are always cheery--every day. The staff, being human, is not always cheery.
- One single row of chairs in a semicircle forces the waiting women to sit up close to a demonstration. The staff, on the other hand, will often forget to call all the ladies to sit up close.
- A large photographic poster of a dramatically unhealthy and/or healthy mother (and baby) can stimulate discussion of family planning among the waiting "audience"; it might do this better than a staff member, even if and when the staff member has the time and the inclination (both often lacking) to start such a discussion.

UNIT SUMMARY

The staff, because of many reasons, including having other duties, is not always "working" on the necessary educational and motivational tasks in the clinic. On the other hand the physical setting and arrangement of the clinic is always "working" towards whatever specific educational/motivational goals you have defined.

SOMETHING TO DO

The activity below has been provided to stimulate more thinking on the ideas in this unit. It can serve as the basis for discussion sessions when the module is used with groups.

ACTIVITY D: DISCUSSION QUESTIONS ON THE PHYSICAL SETTING AND ARRANGEMENT OF THE CLINIC

Please note that questions and problems on the physical setting have been covered in several other sections of this module: The Photograph Analysis (Activity A), the Discussion Questions on methods of clinic education. For that reason you should, at this point, merely add to this list of the kinds of things in the physical environment which can be manipulated. In addition, add ways that they can be manipulated (in the right hand column).

Physical Things	Ways to Adjust
1) Seating arrangements	a) Semicircular to encourage discussion b) Close to speaker for better vision and intimacy, closeness c) Perhaps around small tables, for comfort, to encourage discussion
2) "Educational" materials on walls	a) Posters of high quality, large, dramatic, to encourage discussion b) Poster series to provide more information. An educator or literate client can read out loud the poster captions c) Methods display, with actual materials tied to wall with string d) Pictures of satisfied clients or staff

Physical Things	Ways to Adjust
3) Other things on walls to brighten or personalize the clinic	
4) Location of other furniture	
5) Special area or provisions for noisy children during the educational talk? At other times also?	
6) Other environmental changes which can be temporarily made during the educational talk to decrease distractions or facilitate learning	
7) Physical comfort of those waiting: (heat, cold, shade, water, etc.)	
8) Other floor plan changes?	
9)	

Physical Things	Ways to Adjust
10)	
11)	
12)	
13)	
14)	

WHAT SHOULD BE DONE WITH DISSATISFIED CLIENT WHO IS ON A RETURN VISIT TO THE CLINIC

We raise this commonly faced, very difficult question in this unit since part of the solution may lie in "physical" arrangements: Should dissatisfied clients be scheduled to come at a special time, special day, or be seated separately from the other clients? Can they receive any special education or information that may reduce their anxiety, if that is one contributing cause to physical dissatisfaction? Should some be seen immediately by clinic personnel instead of staying in the waiting area?

Our two main goals with the returning dissatisfied clients are, first that their problems be overcome--often by medical and/or educational "treatment." Second, we are concerned that they do not unduly influence other clients who are in the clinic waiting area.

Make notes on your ideas below:

SELF-TEST

Check your own progress by answering the following questions:

1. Write at least one reason why the atmosphere and physical setting of the clinic is important for clinic education.

2. List and explain at least three things that can be done to adjust the clinic setting to make it more pleasant and receptive to family planning clients.

ANSWERS TO THE SELF-TEST ARE ON THE NEXT PAGE

ANSWERS TO SELF-TEST

1. A cold, business-like atmosphere can make a client (1) unwilling to ask questions, (2) unwilling to refer others to the clinic, or (3) reluctant to return. (Note: You should have listed at least one of the three.)

2. a) brightly painted walls

   b) seating arranged to support demonstrations and discussion

   c) a large poster to stimulate discussion

   (Note: You may have listed other, equally important things.)

Notes and Reactions

UNIT VI

CLINIC PERSONNEL

UNIT OBJECTIVES

When you have completed this unit, you should be able to:

1. Explain why "standard operating procedures" are helpful in achieving effective clinic education.

2. Identify at least two educational tasks for each of the following key clinic personnel: physician, nurse, midwife (or other para-professional).

3. Explain reasons for and against using para-professionals as clinic educators.

GETTING STARTED WITH YOUR OWN EXPERIENCE

Below you will find a number of "critical incidents" about staff roles in clinic education. These are real incidents that have taken place in family planning clinics. Read each incident, then identify the problem or problems that the incident illustrates and write in your suggested solutions.

Incident One

A woman of about thirty-five excitedly walked into a family planning clinic. She approached the receptionist-midwife and said, "I'd like to try family planning. I'm interested in using the IUD. My friend had one and she said it's really good and reliable."

The midwife gladly attended to the woman, saying to herself, "Wow, this is one of those lucky days! Walk-in client and IUD right away! This woman is highly motivated; I don't need to talk to her anymore."

Then she proceeded to register and fill out a record for the woman. After getting through with this routine, she ushered the client into the examination room, saying, "Mrs., go right in and I'll prepare you for the doctor. In a short while, the doctor will be here to take a look at you and fit you with an IUD."

After a little while, the doctor came in with an assisting nurse and prepared "to do a job." Turning to the woman, he said, "Please put your feet up on the stirrups."

From the sterilizer, the nurse took out a speculum and handed it to the doctor. The latter then proceeded to insert it into the woman.

"My God! What are you doing to me? What is that thing you are inserting? It is so big! My husband might think I have been sleeping with another man."

"You shouldn't be alarmed, Mrs. Why, I'm only using a medium-sized speculum! If I don't put this in, I won't be able to see a thing and I won't be able to know where to put the IUD."

"But doctor, I didn't know I would have to go through this procedure to have an IUD. When I saw an IUD insertion demonstration, I saw a very tiny inserter being used, not a speculum! My friend should have told me! If I had known that I would have to be opened up with a steel instrument, I would not have come here. How is this now? You see, my husband is a very jealous person. He might think I slept with another man already."

Problems:

Solutions:

Incident Two

Joe and Evelyn were newly-married and they decided that they did not want to have children yet. Both in graduate school, they felt that they should get their degrees first before starting a family, so they went to a family planning clinic.

They were greeted by a smiling, middle-aged woman who turned out to be the in-house receptionist-motivator. Evelyn told her of her plan to contracept. The motivator took out some forms and started to ask the couple some questions. One question was, "How many children do you have?" When the couple answered "none yet," the woman looked at them quizzically and said, "Then why are you here?"

"Why, don't you serve non-parents here?" Joe asked. "We always thought family planning was also for those couples who don't want to have children yet."

"Well, I don't believe in that kind of thing. Why don't you just come back when you already have your first child?"

"But we believe in that kind of thing," Evelyn protested.

After some more arguing, the woman was finally persuaded to register the couple. Then she said to Evelyn, "Okay, you win. But if I were you, I'd really make sure first. Anyway, here's your pack of pills. Take the first pill on the fifth day of your menses. Then come back next month after you have your period."

Problems:

Solutions:

Incident Three

Mercedes woke up very early that morning. The family planning motivator she met at the sari-sari store the day before had warned her that there would be many people at the center that Wednesday.

Mercedes is a young woman of twenty-nine. She married young and had children, one after another. After having her fourth, she told her husband, "I've had it with bearing children." He agreed with her.

When Mercedes arrived at the center, there were already about fifteen women milling around the entrance. Many had their market baskets with them.

At about 8:00 a.m., the midwife arrived and immediately told the waiting group, "I'll attend to you in a while, ladies. Please get a number. The doctor should be in by 8:15." She then gave each woman a number and proceeded to register them.

A few minutes later, the doctor came. She was a tall, heavy-set woman who had her nose high up in the air. She surveyed the women in the clinic, who by that time had almost doubled in number.

Then she gasped, "My God! Where did all these people come from? This is certainly going to be a very hard day! I'm sure my day will be spoiled by all these people! Hmmmppphhh!"

Turning to the midwife, she said, "Hurry up and be sure you register all those people. Send me the first patient now!"

The midwife motioned one pregnant-looking woman to follow the the doctor to her room.

There was only a single-wall partition and a swinging door that divided the doctor's office from the rest of the center. It was easy to overhear what was going on behind.

Mercedes' eyes widened as she heard the voice of the doctor. "My God, you're pregnant again! I thought you were on family planning. This is your eighth, isn't it? You're too much! Tell your husband to put a little more control on his brakes. He must be too hot!"

Mercedes turned around and saw the same apprehensive look on the faces of the waiting women in the center. She approached the midwife and said, "Please tell your motivator, Mrs. Lopez, that I came today. And tell her, too, that I have decided to go to another family planning center."

Problems:

Solutions:

Incident Four

One day, a newly-appointed field director dropped by to visit a family planning clinic. The clinic hours posted on the entry door said clinic started at 1:30 in the afternoon. But when he arrived at 1:30, there was no clinic staff in sight. He decided to wait.

At 2:00, a midwife came. She had with her a big bag full of fruit. The field director started to introduce himself but the midwife cut him short and said, "If you're looking for the doctor, she won't be in till 3:00. You know, she still has to attend to her sidelines."

While she was saying this, she kept looking at the director's bag which looked similar to those carried by drug salesmen. She must have mistaken him for one.

"Sit down if you care to wait," the midwife said. Then proceeded to call out the clerks and secretaries in the nearby offices. She asked them to join her in eating fruit.

The field director decided to sit through the scene being played before him.

"Have some fruit," the woman invited.

The director politely said, "No, I'll just sit here and wait till the doctor comes."

So the midwife and her friends went on with their feast. She was, however, disturbed when a client walked in and asked for the doctor.

"The doctor is not here. Just come back later!" Then she turned her back to the client and went back to her friends.

A little later, another walk-in client arrived. She, too, was dismissed by the midwife.

"These patients are very annoying. They come when you are busy," she muttered.

The field director finally could not contain himself. He went to the midwife and said to her. "Do you know what you just did? You just let two walk-in clients get away. Don't you know that walk-in clients are very highly-motivated clients? Even if they were asking for the doctor, you could at least have offered to attend to them in her absence."

Problems:

Solutions:

NOTES FROM THE EXPERIENCE OF OTHERS

INTRODUCTION

In every country, "developed" and "developing," there are great social and cultural gaps between the medical-paramedical staff and the majority of the clients served in government facilities. This is especially true when programs expand to the rural areas.

The unfortunate truth is that, because of the socio-cultural gap, the staff frequently lacks the motivation and ability to truly communicate with and educate the client. Of course these are exceptions. We are talking about programs of massive size which are needed to solve the population problem.

"Training programs" for staff can only have limited effectiveness in "motivating" staff to want to communicate and then show them how to do it. We can't count on a few days or weeks of "staff training" to overcome what may be a lifetime of unconcern, or even prejudice, by staff for clients of lower social status.

We are therefore suggesting that a well-planned and tested "standard operating procedure" for clinic education be instituted, and required. We cannot "require" that a busy staff have a true human concern for every client. But we can require that certain things be done to insure that at least the client's education is adequate.

In this system each "resource" of the clinic system has a set of specific educational tasks. "Resources" include everything from the seating arrangement in the waiting room to the specific words and actions that each staff member is expected (required) to perform.

This standard operating procedure is not a new concept. It has been very successfully used by everyone from airline stewardesses to those in medical training and business management. It can easily be used for clinic education.

We must assume that such procedures will be carefully researched and designed before being implemented. One way to do this is to first observe what is done in the very best of the clinics and what things are done by the very best of the personnel. These are then written down and "packaged" in a form similar to the sample one we have included in this section of the module.

In another section of the module we have shown that even with a standard operating procedure some problems will still need solutions: The clinic educators quickly get bored giving the same twenty-minute talk several times a day. Also, some personnel are embarrassed to discuss certain topics as frankly as clients do.

Few doctors have the time or inclination to do client education. "Paramedicals" of all kinds can do a good job of education. One problem is that they may lack credibility in the eyes of the client. Physicians therefore should "publicly" in the clinic "give credibility" to those who are doing the education. That is to say, in front of the waiting clients the physicians should say and do things which will cause the clients to accept the words of the clinic educator. (Indeed, they should give this credibility to all the paramedical staff--not just the educators.)

People tend to teach in the same way they were taught. Since "health educators," "fieldworkers," etc., are taught in their training about ovaries, Fallopian tubes, oviducts, etc., they frequently pass this complicated anatomical information along to the client, who may become confused. The best solution is to frequently remind the educators, during their training and work that such information is not to be routinely passed along to clients. That is to say, this distinction should clearly be made to trainees: Between what is for their background information, and what is to be routinely passed on to those they are "educating."

THE CLINIC PERSONNEL: THEIR VARIOUS ROLES IN CLIENT EDUCATION, AND THEIR RELATIONSHIPS WITH EACH OTHER

We should view the entire clinic and add its parts as an educational system. The system includes educational resources: things and people (staff and clients) and the process in which all these are designed to interact. The client, in passing through the clinic, is exposed to the various parts of the system, one after another. To utilize this system, we must (1) decide what is the total educational task, (2) break the educational task into parts, (3) refer to our message priorities (see Unit III), and (4) assign certain parts to each component of the system.

As an example, this might be a list of some components of the system, each of which should have a part of the total educational task.

1. Sign outside clinic
2. Type of building and cleanliness, appearance, etc.
3. Receptionist, nurse, educator, statistics gatherer
4. Posters and other things on walls, other educational materials in the clinic
5. Other waiting clients and discussions among them
6. Clinic educator and her educational materials
7. Nurse and doctor and things they do to educate or reinforce
8. Nurse, contraceptive distributor, receptionist
9. Take-home pamphlets

Take a few moments to answer the following questions:

1. We should picture the client as someone passing through the clinic and coming in contact, one after the other, with a series of clinic staff. What should be the specific educational tasks of each of those various kinds of staff members?

2. How should the various kinds of staff be trained, or otherwise prepared, to do client education? What should be the curricula for each? What should be training methodology? (This important question of staff training should be raised here, but not a lot of time should be spent answering it. That long and involved question is more fully discussed in a separate module.*)

3. To what extent can "staff training" assure improvements in staff-client or staff-staff relationships? To what extent can "training" really improve problems in client education which are caused by the socio-economic-cultural gap between staff and clients?

*Francine J. Hickerson and John Middleton, Helping People Learn: A Module for Trainers (Honolulu: East-West Communication Institute, 1975).

4. Can we "train" clinic staff to be able to and willing to effectively communicate with clients whom they often feel are their socio-cultural inferiors? If the answer is "probably no," what can we do?

   a. Get staff who are willing? Is it therefore partly a recruitment problem?
   b. Get staff who do not have such a cultural gap with clients?
   c. Assign educational and "receptive" tasks to those categories of existing personnel who are willing and able?
   d. Provide a detailed, carefully conceived and tested standard operating procedure for each staff member? (See example below.)
   e. Use tape players and other automated audiovisual devices?
   f. Use combinations of the above?
   g. Other:

5. What can be done to avoid the common problem of the client getting conflicting information about a variety of family planning topics, from different staff members of the same clinic. How is this conflicting information contributing to increase dropout rates?

_____

_____

_____

_____

_____

To help to conceptualize question 1 about the roles of various clinic personnel, you should fill in the chart Clinic Education Standard Operating Procedure. You may put in the "ideal" or the actual practice, or both (one on a separate page). Some incomplete examples are given. Notice that this chart not only lists personnel and tasks, but also shows where and when messages are given. Thus this chart can be used with a message priority list (see Unit III) to build an overall standard operating procedure or an overall plan for clinic education. Use the space available to complete the chart beginning on the next page.

A chart such as this, when completed by clinic staff, can serve as the STANDARD OPERATING PROCEDURE for clinic education. It tells the staff who is expected to do what, when and where.

CLINIC EDUCATION STANDARD OPERATING PROCEDURE

Personnel	Educational, motivational, reinforcing tasks	Purpose	Where and when	Message (from priority list)
Doctor	A) Goes to waiting room once each hour and, in sight of those clients waiting, briefly speaks to health educator or nurse educator, etc.	A) To legitimize the "message" and "person" of the health educator in the eyes of clients.	Waiting room or waiting area.	—
	B) Introduces herself/himself to those waiting and suggests that they listen carefully to the "important message of the health educator."	B) To let those waiting for the first time know what and who is behind the forbidding door to the examining room; to decrease anxiety in those waiting (so can learn better); to legitimize the "message" and "person" of the health educator in the eyes of the clients.	Waiting room or waiting area.	—
	C) May publicly wave to or greet a returning "satisfied" customer.	C) To "legitimize" and support satisfied users.	Waiting room or waiting area.	—
	D) May tell audiences that she or, in the case of a male doctor, his wife uses the same	D) To publicly indicate her/his confidence in the pill.	Waiting room or waiting area.	"Pills are safe; others use them."

Personnel		Educational, motivational, reinforcing tasks		Purpose	Where and when	Message (from priority list)
Doctor (cont.)		pills that the health educator has just shown or will show them.		(Legitimize the contraceptive method.)		
	E)	Greets clients by name. Congratulates them on their wise decision to start/ continue family planning.	E)	Reinforce client's decision.	Examining Room: (Before and after any exam).	Using family planning is a wise decision.
	F)	Explains examination procedure in manner designed to relieve anxiety.	F)	Relieve anxiety.	Examining Room: (Before and after any exam).	Family planning is safe.
	G)	Quickly repeats and reinforces key ideas stated by clinic educators especially those dealing with safety (and perhaps side effects).	G)	To 1) repeat and 2) legitimize some of the "message."	Examining Room: (Before and after any exam).	On side effects.
	H)	Gives take-home instruction booklet; indicates its importance and says that the nurse/ educator will later tell them the details of how to get someone to read it to them at home.	H)	It is important for doctor to give them the booklet/ pamphlet, and that the doctor say it is important. This legitimizes the booklet even more.	Examining Room: (Before and after any exam).	—

Personnel	Educational, motivational, reinforcing tasks	Purpose	Where and when	Message (from priority list)
Nurse				

Personnel	Educational, motivational, reinforcing tasks	Purpose	Where and when	Message (from priority list)
Health Educator				

Personnel	Educational, motivational, reinforcing tasks	Purpose	Where and when	Message (from priority list)
Midwife				

Personnel	Educational, motivational, reinforcing tasks	Purpose	Where and when	Message (from priority list)
Auxiliary Nurse				

Personnel	Educational, motivational, reinforcing tasks	Purpose	Where and when	Message (from priority list)
Other				

Personnel	Educational, motivational, reinforcing tasks	Purpose	Where and when	Message (from priority list)
Other				

UTILIZATION OF PARAMEDICAL PERSONNEL

More and more administrators, educators and doctors are seeing that the doctor has little, if any, time to do an adequate job of education in the clinic, and often does not have the desire nor ability to do this task. The same is frequently true for the nurse as well.

Yet some people say that the "credibility" of the doctor is an important factor in educating the client. They say that "paramedicals" are less effective as educators since they lack a certain kind of "authoritative" credibility in the eyes of the client. We disagree somewhat with that idea. This typical, unsophisticated village client regards most all staff members as being credible. (In other ways, paramedicals may be more credible than the doctor since the client can more easily identify with the paramedical, and vice versa; this is the "homophily" principle described by Everett Rogers.) We further contend that if the message is kept simple, as it should be, (see Unit III) and not anatomical/physiological or theoretical, then paramedicals of all kinds can do a good job of client education.

PROFESSIONALS CAN CONFER CREDIBILITY TO PARAPROFESSIONALS

1) In what ways, however, can the doctor (or the system) "lend credibility," in the eyes of the client, to the nurse or other paramedical personnel: How can the doctor reinforce or "legitimize" either what they say (their message) or better yet, themselves as people? 2) Are doctors (or nurses) willing to do this "lending of credibility" to staff members who are of lesser status than they? What can be done about this?

TRAINING THE CLINIC STAFF

What are the skills in communication and education that the various staff members should have? Below we have listed some skills--you should add more skills to the list, and indicate which of the staff should be trained in how to do those tasks. Be as realistic as possible since obviously not everyone can be trained in everything.

Examples of job tasks	Personnel to be trained in those tasks
1. Speaking to a group of clients	Health Educator, Nurse
2. Interviewing a client	Nurse, Doctor, Social Worker, Health Educator
3. Use of audiovisuals	
4. How to get a group discussion started among clients	
5. Use of vocabulary which is understandable to client	
6. Speaking to individuals	
7. Detecting uneasiness in clients	
8. Ways to put nervous clients at ease	
9. How to answer common questions like "Does the loop wander around in my body?"	
10. Ways to supervise other clinic educators	
11. How to prepare a client for the questions that will be asked by spouse, relatives, etc.	
12. Teach client how to utilize take-home pamphlets	
13. Completing client information needs assessment	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

A job/task list such as the one on the previous page can serve as the basis for designing both pre-service and in-service training for clinic personnel.

PAID VS. VOLUNTEER STAFF

More and more clinics are realizing the value of having some volunteer staff. Volunteers bring a fresh commitment to the work in the clinic. They are "that additional person" the clinic has been needing to be able to offer quality service. With volunteer staff the clinic may be able to offer services it could not have offered otherwise.

But this also brings a whole new set of problems. The volunteers need to be trained the same as the paid staff. If the volunteers are doing the same amount of work as the paid staff they need to have equal say in any clinic decisions, or at least agreements have to be reached on who has input. What other problems can you see that may occur between paid and volunteer staff?

_____

_____

_____

_____

How can each problem be solved?

_____

_____

_____

_____

UNIT SUMMARY

Our clinic personnel are the most important component of the clinic education program. Their attitudes, skills, and job performance are the difference between a program that helps fight the drop-out problem and one that does not.

There are limits to what can be achieved with training. However, by designing standard operating procedures that analyze the educational tasks of the clinic and assigning them (and messages) to specific staff to be done at a certain point in the client's visit to the clinic, we can improve the quality of the program. We can help avoid having various staff members giving different information, or giving information at the wrong time. We can also make sure that our message priorities are met through the total clinic experience.

Para-professional workers can carry out much of the clinic education task, freeing the physician and nurse for medical work. Para-professionals, if they have similar backgrounds to clients served, can be effective communicators. Para-professionals, of course, may be less "credible" to clients than a physician, although this can be dealt with by having the physician give them support, by keeping messages simple, and by making sure that technical and medical information is given by the physician.

SOMETHING TO DO

The exercise below has been provided to stimulate more thinking on the ideas in this unit. It can serve as the basis for discussion sessions when the module is used with groups.

ACTIVITY E: DEVELOPING YOUR OWN CLINIC STANDARD OPERATING PROCEDURES

We have provided several pages of forms for developing standard operating procedures. Refer to the message priority checklist in Unit III and use these forms to construct a plan for education in your clinic.

We suggest that you begin by first listing the staff who will be involved, and then complete the rest of the form.

STANDARD OPERATING PROCEDURE FORM

Personnel	Educational, motivational, reinforcing tasks	Purpose	Where and when	Message (from priority list)

Personnel	Educational, motivational reinforcing tasks	Purpose	Where and when	Message (from priority list)

Personnel	Educational, motivational reinforcing tasks	Purpose	Where and when	Message (from priority list)

Personnel	Educational, motivational reinforcing tasks	Purpose	Where and when	Message (from priority list)

SELF-TEST

Check your own progress by answering the following questions:

1. Explain why standard operating procedures are helpful in achieving effective clinic education.

_____

_____

_____

_____

2. Write down at least two educational tasks for each of the following key clinic personnel:

Physician: 1) _____

2) _____

_____

_____

Nurse: 1) _____

2) _____

_____

_____

Para-professional: 1) _____

2) _____

_____

_____

_____

3. Explain reasons for and against using para-professional personnel in clinic education.

ANSWERS TO THE SELF-TEST ARE ON THE NEXT PAGE

ANSWERS TO SELF-TEST

1. Standard operating procedures enable us to clearly assign educational tasks to clinic personnel; to train personnel carefully; to insure that all important messages are delivered by the right people at the right time in the right place: to insure that staff do not provide different or conflicting information, etc. (you may have additional reasons).

2. Physician:
   1) give credibility to para-professionals
   2) provide reassurance on side effects

   (you may have identified many other tasks)

   Nurse:
   1) identify uneasiness among clients
   2) administer information needs questions

   (you may have identified other tasks)

   Para-professional:
   1) explain benefits of family planning in words/terms familiar to clients
   2) lead group discussion of family planning

   (you may have identified many other tasks)

3. For: Para-professionals can relieve physicians and other professionals of more routine duties; they can be effective communicators with clients who have the same backgrounds that they do.

   Against: Para-professionals may not be as "credible" as physicians and nurses.

Notes and Reactions

UNIT VII

EVALUATION

UNIT OBJECTIVES

When you have finished this unit, you should be able to:

1. Identify two major aspects of clinic education that are important to evaluate.

2. Explain a "spot-check" method for evaluating clinic education.

GETTING STARTED WITH YOUR OWN EXPERIENCE

The exercise below is designed to help you begin this unit with your own experience and ideas. Answer the following questions:

1. Is evaluation of the educational program done in the clinic(s) that you work with? If so, how is it done?

2. What aspects of the clinic education program should be evaluated? List at least two.

3. What are some ways of collecting information about the effectiveness of a clinic education program?

NOTES FROM THE EXPERIENCE OF OTHERS

We know, of course, that clinics play a very important part in the overall system of evaluation for family planning programs. In almost every program around the world, the clinic is the place where acceptor statistics begin their long journey into annual reports of program accomplishment. In almost every clinic, we can find some record of accomplishment. Often we find charts on the wall showing numbers of acceptors for each kind of method for the past report period.

Evaluation of this kind is critically important. It gives, however, only a very general picture of how well a clinic education program is working. Clearly, if the clinic is getting no acceptors, or many dropouts, then something may be wrong with the education program. Put how do we know what that "something wrong" is? To answer this last question, clinic educators need to develop some basic evaluation systems for the education program.

TWO MAJOR ASPECTS: OUTCOME AND PROCESS

In evaluating the clinic's education program, we need to look at two things. The first can be called the outcomes of the program. We want to find out if clients learned what we intended. Have clients mastered the information in our priority messages?

The second thing we need to look at is the process of the education program. Are messages being shared with clients at the right time, in the right place, by the right personnel? In short, are our standard operating procedures working well? If not, how should they be changed?

The Spot-check Method

Suppose we want to find out if a client who is just leaving the clinic has received an adequate education. A simple, yet effective method is to ask the client some very specific questions. We can call this a "spot-check" method. These questions should be based directly on the messages that we have built into our standard operating procedure. Some example questions are given below. Note that these these questions are not general, such as "Did you understand how the pill works?" or "Did you understand what the health educator said?" Notice also that there are questions both for outcome and process. Use the space provided (n through q) to write a few questions of your own.

___ a) "What will you do if you have some cramps tomorrow with your new IUD?"
___ b) "What day and time will you return here to the clinic for a follow-up check-up?"
___ c) "What will you do if you forget to take a pill for one day?"

___ d) "What will you do if you forget to take a pill for two days?"

___ e) "What things will you say or do when your neighbor says that your new IUD can be dangerous?"

___ f) "When your husband asks you what effect the IUD will have on your sex life, what, exactly, will you say to him?" "If he asks you about your future ability to have children, what, exactly, will you say?"

___ g) "What will you do with the pamphlet that the doctor just gave you when you return home?"

___ h) "What will you do if you want another baby in the future?"

___ i) "What kinds of things (side effects) can temporarily happen to make you feel uncomfortable? If they do occur, how long can they last?"

___ j) "What did the educator (doctor, cassette tape machine, nurse) say about your future menstrual periods?"

___ k) "Did anyone in the clinic say something which makes you feel that the pill (IUD) is safe?" "Who were those people?" "What things did they say?"

___ l) "What did the educator (nurse, doctor, cassette tape machine) say about the common but untrue stories you have heard regarding the safety of the pill (IUD)?"

___ m) "When will you take your first pill?" "When will you take your last pill?"

___ n) _____

_____

___ o) _____

_____

___ p) _____

_____

___ q) _____

_____

As you can see, these evaluation questions listed above should be based exactly on the kind of information that the clinic is trying to teach. This means that the questions should be prepared after the standard operating procedure has been completed.

Take a few minutes to review the questions again. Write an "O" beside the outcome questions, and a "P" beside the process questions. Our answers are given below.

Answers: Process (P): j, k, l. Outcome (O): all others.

NOTE: WE ARE NOT SUGGESTING THAT THE ABOVE COMPREHENSIVE TYPE OF INTERVIEW BE DONE WITH EVERY CLIENT; BUT RATHER ONLY AS A "SPOT-CHECK" EVERY FEW MONTHS TO SEE HOW THE CLINIC EDUCATION "SYSTEM" IS FUNCTIONING.

One further point: As the reader knows, there are differences of opinion about the value of teaching anatomy and physiology. To those readers who still think they should be taught, we suggest that you ask your clients the above questions. Studies indicate that clients frequently cannot answer, even though they are not very difficult. The more difficult topics of anatomy and physiology are even less well understood by clients.

Another way to help decide what kind of evaluation to do is to ask yourself the following three questions which are related to the well-known "K.A.P." studies: "When the clients leave the clinic, what do you want their knowledge to be, their attitude to be, and their practice to be?" We will list some examples; you may wish to list more.

1. Knowledge - a. Side effects are temporary
   b. The pill does not cause cancer or weakness
   c.
   d.
   e.
   f.
   g.

2. Attitude - a. The client will feel confident that she knows how to handle any side effects; feels she can confidently explain to husband
   b. The client will feel good that she made a wise choice to practice family planning

3. Practice - a. Talking about family planning to her neighbors, relatives, friends
   b. Opening a pill package
   c.
   d.

This evaluation procedure, of course, is closely related to the client needs assessment described in Unit III. In fact, the two procedures can be very closely integrated. Informal spot-check questions can be asked of a relatively large number of clients. Ocasionally, it may be a good idea to integrate needs assessment questions with evaluation questions and to carry out a series of more formal interviews.

USING EVALUATION INFORMATION

What kind of information will we get from this kind of evaluation? One thing we will find out is whether our clients can remember the information given them during the clinic experience. If they can, we are reasonably sure that our program is working. If, however, they cannot remember instructions for use of the pill, or describe the side effects of the IUD and what to do about them, we must review our procedures to strengthen the program.

Here the process questions are helpful. If we find that clients cannot explain pill use, and also say that the instructions from the nurse were given too quickly, we can help the nurse talk more slowly. We can also look at our message priorities to find out if the instructions are repeated during the clinic experience. If not, we may wish to have them given again at a different point in the clinic.

After making changes we can continue to ask the same questions to see if improvement takes place.

UNIT SUMMARY -- AND A REVIEW

Let's combine a summary of the ideas on evaluation with a review of the full process of designing and evaluating a clinic education program. Here are the major steps in the process:

1. Identify the characteristics of major client groups.
2. Assess client information needs
3. Develop message content and priorities
4. Design messages with
   - appropriate vocabulary
   - sufficient repetition
   - appropriate timing
5. Pretest messages
6. Select a variety of media which fit with clinic conditions
7. Arrange clinic atmosphere to support the education program
8. Develop a clinic standard operating procedure based on message priorities that plans for message delivery by different personnel at appropriate points in the client's clinic experience
9. Develop a spot-check method of evaluation based on the standard operating procedure that provides information on both the outcomes and process of the education program
10. Use evaluation information to modify standard operating procedures.

SOMETHING TO DO

The exercise below has been provided to stimulate more thinking on the ideas in this unit. It can serve as the basis for discussion sessions when the module is used with groups.

ACTIVITY F: ONE WAY TO EVALUATE CLINIC EDUCATION: ROLE PLAY OF AN INTERVIEW-TYPE EVALUATION

Purposes: To illustrate and practice one simple way to evaluate the extent of client learning. It can be used to evaluate the educational job done by the clinic.

Time: 1-1/2 hours

The object of this exercise is to devise a way to evaluate the extent to which a client has been adequately educated during the time she was in the clinic. Let us assume she just received an IUD at the clinic. She was also given the usual educational "talk" or demonstration, etc. She is now walking out of the clinic to return home. Your task is to design an interview or series of questions that you will ask her that can tell you how well that clinic is educating its clients.

PROCEDURE

Summary of the Activity:

- 5 minutes to read these instructions
- 15 minutes to plan the eight evaluation questions (in teams of three people)
- 10 minutes for role play of "Evaluator" and "Client"
- 30 minutes to put evaluation questions on the board and discussion by the large group
- 30 minutes for group discussion of the five discussion questions listed at the end of this activity

The large group will break into teams of three. The job of each team is to design eight questions that one team member (the "evaluator") will ask the "client" to see what she learned. The

questions should be carefully worded and written out on paper. The "evaluator" should imagine that he is in a real-life situation; thus he must also plan his role play of how he will introduce himself to the client, sit down, begin the discussion, and finally, ask the eight questions.

Take fifteen minutes to plan the questions. Do not ask questions that can be answered with a "yes" or "no" answer, like "Do you know what to do if you get some cramping with your IUD?" This "yes" or "no" kind of question does not prove to you that she has learned what to do if she gets cramps. A better way is to ask: "What will you do if you get cramping with your IUD?"

We will then ask for (male or female) volunteers to play the role of "The client who just got the IUD, and who is ready to leave the clinic." She will be interviewed by the "evaluator" using the eight questions the team of three developed.

> [Note to volunteers on how to play your role as the "client": You are from a rural area of the country. You are not accustomed to talking to strangers, especially ones from the city. If he or she does ask you a question that you can answer with only a "yes" or "no" answer, then do answer it in that short way. Give the evaluator a fuller answer only if the question is worded in a way that makes you give a fuller answer.]

The actual role play of the interview/evaluation should take about ten minutes. If there are more than three teams, all the role plays should be done simultaneously, in different corners of the room. After the role plays, the teams will all come together to form the large group.

Then each team should write on the blackboard the eight questions they composed, with a star by those which seemed the most helpful in the actual interview and an "x" by those that were not helpful in the interview.

The large group should then discuss which questions seem the best for this purpose of evaluating the total clinic education.

In the last thirty minutes of the 1-1/2 hour session there should be a discussion of these points:

1. How practical is this method of evaluating the clinic's program of education?

2. How many times per year should such a "spot-check," or or evaluation, be done in each clinic? How many clients need to be interviewed to tell how good the clinic education program is?

3. Who should do the evaluation? local staff? outsiders? both?

4. What should be done if it is found that the client cannot adequately answer three-fourths of the questions? Half of the questions?

5. What are methods besides the "client interview" of this activity that can be used to evaluate the clinic's educational program?

You can note down the answers to these five questions in the space below. You may also wish to write down the "good" evaluation questions which were listed on the blackboard.

SELF-TEST

Check your own progress by answering the following questions:

1. Write down the two aspects of clinic education that are important for evaluation.

2. Explain the "spot-check" method of clinic education evaluation.

ANSWERS TO THE SELF-TEST ARE ON THE NEXT PAGE

ANSWERS TO SELF-TEST

1. The two aspects of the education program important for evaluation are outcomes (whether the client learned what was intended) and process (the way in which the information is given during the client's clinic experience).

2. The spot-check method involves (1) constructing questions that test whether the client learned the messages of the program and that find out how the process worked; (2) asking these questions of clients (not all clients) after the clinic experience; and (3) using the information to improve standard operating procedures.

Notes and Reactions

UNIT VIII

CONTINUING EDUCATION IN THE COMMUNITY

UNIT OBJECTIVE

When you have finished this unit, you should be able to:

1. List and describe at least three methods for arranging continuing education, motivation, and support of clients once they are back in their community.

GETTING STARTED WITH YOUR OWN EXPERIENCE

The exercise below is designed to help you begin this unit with your own experience and ideas. Answer the following questions.

1. Are the clinics you work with engaged in follow-up education efforts in the community? If so, describe these efforts. What are the goals? What mechanisms are used?

2. List as many types of community follow-up education as you can, and give a brief explanation of each. Include in your explanation the audiences, goals, and methods for each approach.

NOTES FROM THE EXPERIENCE OF OTHERS

Too often, even with good clinic education programs, we neglect the opportunity we have to continue to provide education, motivation, and support for clients after they are back home. This is unfortunate, because the impact of even the best program can be improved through any of a variety of follow-up education methods.

Follow-up education is especially important for the basic problem that clinic education attacks: discontinuation. Even well-educated clients will have moments of doubt, unanswered questions, or even opposition from family and community. By extending our education program beyond the walls of the clinic we can help these clients overcome their problems.

A CATALOG OF CONTINUING EDUCATION METHODS

Below you will find a "catalog" of approaches to continuing education. These approaches are structured as questions and answers. We hope you will ask yourself the questions, thinking about the clinics with which you work. Then read our answers. In many cases, our answers are incomplete--or may appear to be simply more questions! This is because we feel that many of these questions have yet to be answered fully. We hope that you will use the space provided to add your own ideas and experience to the answers we have begun.

A. Pamphlets

Questions

1. Can take-home, non-illustrated or slightly illustrated printed materials be given out at the clinic? Is this a useful method of continuing education?
2. Can illustrated take-home leaflets and pamphlets be helpful? Could such materials have the same pictures as a flipchart used for in-clinic presentations--so that clients will already be familiar with them?
3. If pamphlets are given out, how should it be done? By leaving them on a table in the waiting room? By having them handed out by a staff member? Given out with instructions for use?

Partial Answers

Illustrated Pamphlets: Is it difficult to develop pamphlets that are so well-illustrated that you don't need written words--so that they can be used by illiterates? It seems that this would be important, but we have yet to see pamphlets that were this well-illustrated. More work needs to be done on this problem.

Non-illustrated Pamphlets: Are there people in client homes who could read these materials if the client is illiterate? Will the client ask for this kind of help? Perhaps we can help the client get this kind of assistance by showing him/her pictures of clients getting help with printed materials at home, and suggest they do the same when they get home.

Reader Comments

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_____

_____

_____

B. Mailings

Question — Is it possible and practical to mail follow-up information/support materials to the client?

Partial Answers — Do clients give the right address? In some countries there are no "addresses" and even if there are, clients give a false address so their spouses do not know they have been to the clinic.

Reader Comments

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_____

_____

_____

C. Follow-Up Visits and Meetings

Questions — Should clinic personnel go into the community through:

1. Individual house visits?
2. Group meetings of acceptors, or any group meeting where acceptors are present?

Partial Answers — Usually the clinic does not have the staff to do follow-up visits to individuals. It is possible, however, that clinic staff will go into the community from time to time to give talks, presentations, and demonstrations to groups in the community where some of the audience are clients, thus reinforcing their decision to continue contraception.

Sometimes there is a local family planning fieldworker in the village who does not belong to the same agency as the clinic. Even so, it may be possible to enlist his or her help. For best effectiveness, this coordination should be done at higher interagency levels as well as locally.

Tape recorded messages can be useful in follow-up visits and meetings. When these tapes contain interesting stories which include family planning information, they can be even more effective.

Reader Comments

_____

_____

_____

_____

D. People in the Community

Questions

Are there other resources and people in the community with whom the client might be told to talk with if he/she has problems, or hears rumors?

1. Another satisfied client who is willing to talk with new clients if they go to her. (The clinic can maintain such a list of "volunteers.")
2. The local druggist, or perhaps indigenous midwife.
3. Local religious leader.
4. Local home economics extension workers if they are known to have some knowledge of and are willing to cooperate with the family planning program.
5. The local fieldworker for family planning.

Partial Answers

Would this mean training sessions for such people? Is it worth the effort? In places where people live too far away from a clinic to return each time they hear a rumor or have a backache, it may be very useful to have such people available who can give advice, or even to merely read the take-home pamphlet again to the worried client.

In the case of the home economics extension worker, it is much simpler to merely ask her to answer such common questions when people come to her (answering them from a well-prepared booklet or by referring the client to clinic) than it is to request that she routinely do family planning work as part of her home economics

duties. She may be willing to carry out this easier, former function and not willing to do the latter function.

Reader Comments _____

_____

_____

_____

E. Other Resources

Question — What other community people and resources can be contacted by the clinic to help provide continue the practice of family planning?

Partial Answer — Other people and resources in the community (leaders of various kinds, religious groups, etc.) can be helpful. But do they support family planning? How can they be used?

Reader Comments _____

_____

_____

_____

F. Spouse

Question — In what ways can the spouse of the client be involved in the education program in the clinic, or through some of the above "extensions" of the clinic into the community?

Partial Answer — Your answers are most important here because they will take your cultural situation into account!

Reader Comments _____

_____

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_____

G. The Satisfied Client

Question Can some current users be selected and prepared to actively promote family planning with their friends and neighbors and to help support or reinforce new users? What are the advantages? Can this preparation be done during the time they are in the clinic? How? Does it necessarily mean that they need special handling? What are the problems with doing it? Is it worth the effort?

Partial Answers See page 1 of Dr. Winfield's chart in supplementary reading no. 5. (all of upper right hand section). It is extremely important that satisfied users be persuaded to talk to their friends and neighbors. This is facilitated by providing one or all of the following:

1. "Training" of an elementary nature; not on "technical" topics.
2. "Incentives" and/or "recognition" via certificates, public recognition by officials, free contraceptives.
3. Materials: simple, illustrated, printed or audiovisual materials to increase basic information and motivation--not to explain anatomy, physiology, method of action, etc. Simple training is needed in how to use these materials.

Since the "satisfied user" is such a credible source of information once he or she is back in the neighborhood, it is probably worth the extra time to give some special attention to assuring that this client "spreads the word." Studies like those at the Chulalongkorn Hospital in Thailand have shown that the news of a family planning clinic can spread throughout much of an entire country by word-of-mouth.

Satisfied clients are looked upon by their neighbors as credible sources of information about family planning, since they are actually practicing the method.

Users have great potential to either help or hurt the program depending on their attitude toward the method, the way they are treated in the clinic, and the information which they either know or don't know.

In addition, the client "users" are receptive to messages about family planning. Such messages cause them to feel that they have made the right decision, and can cause them to tell others about the good decision they have made.

Such satisfied users can be given pamphlets to pass on to others. They may be stimulated to tell their friends about their successful use of contraception, they may be given incentives of "finder's fees"

for bringing someone else in, or given some kind of appointment card which can be used to recruit new acceptors from among their friends.

Reader Comments

H. Postpartum Wards and Other Clinics

Questions

In what ways should the message content and educational approach be different for postpartum wards? For general medical, pediatric, gynecological, or other clinics?

Partial Answer

Postpartum Wards: Messages that congratulate the mothers and talk to them about spacing their children for the sake of both their health and welfare are appropriate for the women in the postpartum wards. Educational aids would need to be portable to carry up and down the wards.

Other clinics: Messages that emphasize family planning and its health and welfare benefits would be most appropriate here. It is a good idea to have a working agreement with the staff of the clinic that they will do referrals to you and will hand out family planning pamphlets. The other clinic staff also appreciate special training on family planning topics and can then be educators in their own clinics of various types.

Reader Comments

I. The Mass Media

Question

To be most effective this approach requires rather close links between the family planning clinics and the mass media. How can this be done?

Partial Answer

When the client is in the clinic, can she be informed of things on the mass media which can both provide her with more information and

legitimize and reinforce in her mind her decision to use contraception. For example: "Listen to this weekly radio program." "Be sure to see the family planning exhibit in the railroad station next time you go to the city."

On the other hand the mass media can be in touch with the clinics to learn what they can do to reinforce the clinic education, counteract rumors, etc.

Reader Comments

J. Clients Returning to the Clinic

Question

In this case the clinic should be viewed by the client as a welcome place that she can turn to if she has questions or problems. If this method is elected, can the clinic be structured to handle the very large numbers of women who are having individual "problems." (We assume that there are large numbers of them because of the large dropout rates). If so, how can the large numbers be handled?

Partial Answer

For those clients who live near the clinic, it may be possible to strongly encourage them to get "individual" follow-up support by returning to clinic.

Reader Comments

UNIT SUMMARY

Continued education, motivation, and support in the community is important in achieving satisfied clients and fighting the drop-out problem.

There are a variety of ways to do this, and each method should be considered in light of clinic staff capability and client needs.

SOMETHING TO DO

The activity below has been provided to stimulate more thinking on the ideas in this unit. It can serve as the basis for discussion sessions when the module is used with groups.

ACTIVITY G: DESIGNING A CONTINUING EDUCATION PROGRAM

In this exercise you will first describe the setting of your clinic and then design a continuing education program that uses at least two methods. You may use methods suggested in this unit or other methods with which you are familiar.

In designing your program, you will want to identify the client subgroup or subgroups for which continuing education is intended and show how the approaches used are integrated with each other and with the basic program of the clinic.

Use the worksheets provided for your plan.

Client Subgroup(s): _____

_____

Continuing Education Methods: _____

_____

_____

_____

_____

A) How will these methods (and content) be integrated with each other?

_____

_____

B) How will the continuing education methods be integrated with the basic in-clinic education program?

C) Other comments on the plan.

SELF-TEST

Check your own progress by answering the following question:

1. List and describe at least three methods for continuing clinic education in the community.

ANSWER TO THE SELF-TEST IS ON THE NEXT PAGE

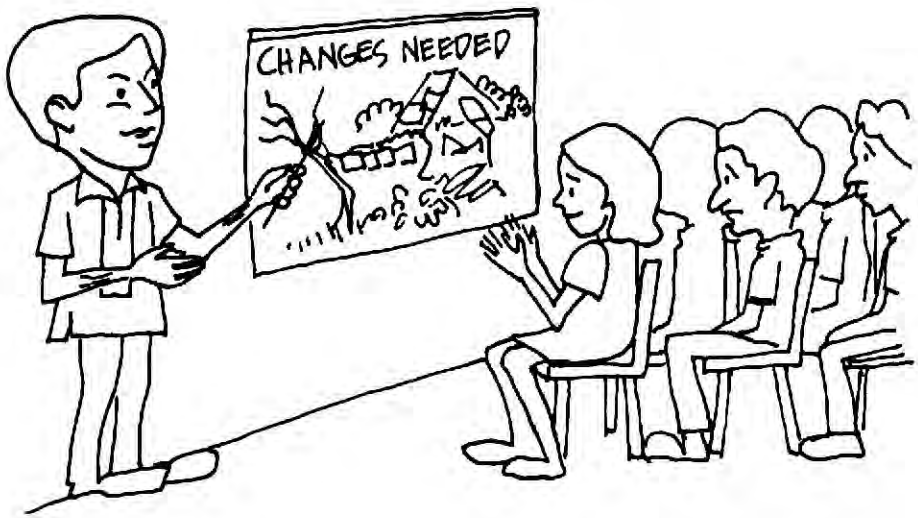
ANSWER TO SELF-TEST

1. Check your answers against the catalog in this unit. You may have listed other methods, and that is fine.

Notes and Reactions

UNIT IX

ADMINISTRATIVE CHANGES



UNIT OBJECTIVE

When you have completed this unit, you should be able to:

1. Describe at least one strategy to use in obtaining support for administrative changes required by the clinic education program.

GETTING STARTED WITH YOUR OWN EXPERIENCE

The exercise below is designed to help you begin this unit with your own experience and ideas. Answer the following questions.

1. What is the general attitude of family planning administrators that you work with towards clinic education? Is it important? Why or why not?

2. How can clinic educators obtain the support needed from administrators for the kinds of changes needed to implement good clinic education programs?

NOTES FROM THE EXPERIENCE OF OTHERS

Our experience as clinic educators has led us to believe that most family planning administrators are not very interested in clinic education. William O. Sweeney, an experienced observer of the family planning movement worldwide, puts it like this:

> "Communications is generally a poor relative in population programs. It is under-financed and under-valued. An examination of organizational charts of national programs often shows that communications is deemed less important than family planning services, research evaluation, and logistics. Yet only two components of programs have direct contact with clients and potential clients: communications and services."*

There are, of course, many reasons why communications has a relatively low priority within programs. Perhaps most important is the emphasis placed by administrators on gaining acceptors. Thus they tend to be more interested in the "action" components--distribution of condoms and pills, IUD insertion, and the supply system necessary to make this possible.

There is no doubt that this supply system is critically important. Without it, there is no family planning program. As clinic educators, we should recognize this fact. This means that administrators are interested in clinic education to the extent that it can achieve acceptors and, perhaps most importantly, lower dropout rates.

Thus it is important to talk to administrators in terms that are meaningful to them. We should show how clinic education can make the program more efficient and effective.

How can this be done? One way is to use a successful clinic (with a good education program) as an example, showing how things of interest to the administrator (acceptors, dropout rates, decreased costs for follow-up) have improved in the clinic. Another is to present a carefully developed plan, emphasizing the benefits that can be expected. A third strategy, and one that can be used together with the others, is to carry out the kind of client needs assessment described in this module to develop evidence that clients do need better education.

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*William O. Sweeney, "Communications Activities That Promote Behavior Change in Clients of Family Planning Programs: Resources and Constraints," in Information, Education, and Communication Strategies: Their Role in Promoting Behavior Change in Family and Population Planning, ed. Lyle Saunders (Honolulu: East-West Communication Institute, 1977).

There are other strategies for achieving administrative change within your clinic system. These strategies will be ones that fit your culture and organizational setting, and which have proved successful in the past. We would only emphasize here that communication with administrators, like communication with any audience, is most effective when it is based on their needs and concerns.

SOMETHING TO DO

The discussion question below has been provided to stimulate more thinking on the ideas in this unit.

1) **Make a list of the needs and concerns of administrators who are responsible for the clinics that you work with. Then, based on these needs and concerns, outline a presentation to them of a new standard operating procedure for clinics. Do not outline your full procedure, but rather concentrate on the arguments you would use to gain administrative support.**

Administrator Needs and Concerns

Presentation Outline

SELF-TEST

Check your progress by answering the following question.

1. Describe at least one strategy to use in obtaining support for administrative changes required by the clinic education program.

ANSWER TO THE SELF-TEST IS ON THE NEXT PAGE

ANSWER TO SELF-TEST

1. Check your answer against the strategies outlined in the unit, and against the strategy you used in the exercise in SOMETHING TO DO.

Notes and Reactions

APPENDIX

A LIST OF MESSAGE ITEMS FOR (IUD) CLIENTS IN THE FAMILY PLANNING CLINIC

Much of the "message" for pill users is, of course, the same. You may wish to develop a similar list for pill users.

These very same items can be included in talks and illustrated flipcharts and posters used in the clinic. The same illustrations can be used in take-home pamphlets. These same messages can also be used in the clinic with routine follow-up clients to help reinforce their continuation.

- The IUD is this small soft plastic object. It is quickly and easily placed in your womb by a doctor.
- The IUD is safe: It cannot cause cancer or weakness (or "headaches," etc., depending on current local rumors).
- The (married) female clinic personnel themselves use the IUD (the pill) because it is safe.
- Wives of the male staff members use the IUD (pill) because it is safe.
- The IUD stays in your womb. It cannot move around in your body.
- The IUD works. You can be almost sure you will not get pregnant.
- If you do want to again get pregnant in the future, just come to the clinic and we will quickly remove the IUD.
- The cost of getting an IUD at this clinic is _____.
- The IUD is very popular. It is used by thousands of people throughout the country. (Some well-known people such as actresses, politicians, etc., who use the IUD (pill) are _____, _____, _____.) Many people in this are, your friends and neighbors are right now using the IUD.
- The pleasure of sex relations will not be changed for you or your partner. In fact they may be more enjoyable now, without the fear of pregnancy.
- For the next two to three months, some of you may experience temporary, crampy pains similar to your menstrual pains. During your

next two or three menstrual periods, some of you may have more blood flow and may feel stronger menstrual pains. These are normal and temporary and should go away in two or three months. You should not worry about these.

- Wearing the IUD is like wearing a new pair of shoes, or earrings. It takes a little time for your body to adjust, that is why you may have some discomfort, until your womb adjusts to the IUD.

- If you do have pains, you can take the following medicine: _____.

- You can return to work immediately after getting your IUD. It will not make you weak.

- If you have problems or questions, you can return to the clinic at the following times: _____.

- Also be sure to ask us any questions you may have before you leave today. All the staff here wants you to be a successful and happy user of your IUD. We will help in whatever way we can, so please ask us.

- You should return to the clinic for a medical check-up if you develop any of the following symptoms: _____. You probably will not have them.

- Come back to the clinic on this date/time _____. We ask all new clients, like yourself, to come back so we can assure that you have the best care, and minimize any discomfort.

- You (and your partner) have made a wise and good decision to practice family planning (and contraception). You are to be congratulated. And at last, you do not have to worry about getting pregnant. That is something to be really happy about. And, your health and your children's health is improved when you space your children and do not have one right after the other.

- Some of your husbands, friends, and neighbors may want to know about your experiences with the IUD. You can tell them things you learned here today. If they want more information you can show them your illustrated picture booklet. If they wish, they can also come here for information.

- In a few months, after you are successful and satisfied with the loop, you may wish to bring some of your friends to the clinic.

- When you return home, be sure to look at and read, or have someone read you this illustrated booklet about the IUD. It repeats exactly all the things we have just said here. You may wish to show the booklet to your spouse or relatives. It is our gift to you.

SUPPLEMENTARY READINGS

The Pill

Clinics Teach Less Than Patients Learn

Family planning clinics in New York City teach their clients far less than they should know about oral contraceptives, two Columbia University investigators told the ninth annual meeting of the American Association of Planned Parenthood Physicians in Kansas City, Mo., last April. According to Dr. Linbania Jacobson, Director of Community Relations in Family Planning, and Elizabeth B. Connell, M.D., Director of Research and Development, at the International Institute for the Study of Human Reproduction, Columbia University, there is a wide gap between what 16 nationally known family planning experts think patients should know for safe and effective use of the pill and what family planning clinics teach. Furthermore, the knowledge patients do have is "not directly related to the instruction given in the respective clinics," they said. On the average, most patients know more than what is taught, though some know less.

The experts were chosen "on the basis of their involvement in clinical investigations and research activities among large pill-taking populations," Drs. Jacobson and Connell said. They were given a list of 94 items related to the pill and asked to rate them as *essential, useful* or *unnecessary* to pill use. They were also invited to add essential items they thought had been overlooked, and make comments as they saw fit.

While the experts were not in total agreement among themselves, at least three-fourths of them agreed that eight basic categories of information were "essential to the effective and safe use of the pill." These categories, with the percentages of experts considering them essential, are listed in Table 1.

To get a sample of what family planning clinics actually teach their clients, the investigators observed clinic sessions in 12 of the largest family planning programs in New York City, rating their educational content on its completeness, its statement in lay terms and the degree to which Spanish-speaking women were addressed in their own tongue. The clinics were sponsored by public and private agencies including municipal and voluntary hospitals, the health department, the Human Resources Administration and Planned Parenthood. As the table shows, the clinics approached the experts' standards only on when to take the first and last pill, with 87 percent handling this topic properly. Beyond that their performance fell off rapidly. Only 54 percent explained possible menstrual cycle changes associated with pill use; 46 percent discussed the theoretical- and use-effectiveness of the pill; 45 percent covered returning for a medical examination and prescription refill, and 43 percent gave instructions on what to do if the pill-taking cycle was broken. Only 25 percent explained the process of ovulation and what to do if specific symptoms occurred. Their scores were even worse when it came to discussing side effects associated with pill use. Only 14 percent—one out of seven—discussed breakthrough bleeding, spotting and thromboembolism. Not a single clinic explained such possible contraindications to pill use as breast-feeding or a previous history of blood clotting.

A total of 60 patients, five from each clinic, were questioned on their actual knowledge of the pill after they had presumably been taught about it.

Table 1. Information Considered "Critical to Safe and Effective Use of the Pill" by at Least 75 Percent of Panel of Experts, Compared with Percentages of Clinics Providing This Instruction and Patients with Adequate Knowledge

Information	*% of Expert Opinion*	*% of Clinics with Proper Instruction*	*% of Patients with Adequate Knowledge*
When to take first and last pill	97	87	71
Possible menstrual cycle changes	87	54	53
When to return for checkup and prescription refill	87	45	70
What to do if one or more pills omitted	81	43	70
Contraindications	81	0	13
Side effects	79	14	24
Basic information on ovulatory cycle and what to do if specific symptoms develop	78	25	43
Theoretical- and use-effectiveness of the pill	75	46	72

That the teaching was largely ineffective can be seen from the following: Only one of every four women supposedly taught about possible side effects they might experience, such as breakthrough bleeding, spotting and thromboembolism, understood them. Even fewer—only one of eight taught—were knowledgeable about the relation of pill use to breast-feeding or to a previous history of blood clotting. Only two out of five women allegedly educated about the process of ovulation and what to do if specific symptoms developed understood either. A better job of teaching was done on the question of when to take the first and last pills, with seven out of 10 women taught understanding the pill regimen. A similar proportion understood when to return for a checkup or a prescription refill. About two-thirds of the women knew what else to do to protect themselves from unwanted pregnancy if they discontinued the pill. More than seven out of 10 taught understood the use- and method-effectiveness of the pill. Less than half, however, understood the ovulatory process, and only about half knew when to expect menstruation to begin and what to do if menses did not begin once they were on the pill.

Living as we do in an age of instant communication, the Columbia investigators stated, it was their opinion that a patient's ability to cope with "frightening, confusing and incorrect stories concerning fertility control techniques such as the pill" depends in great measure on the degree of rapport and trust already established with her physician or clinic personnel. With a good relationship based on warmth, respect, understanding and free and open discussion of the merits and disadvantages of all birth control methods, the patient can be reassured effectively and her peace of mind restored. "If, on the other hand," they said, "such rapport did not previously exist, fear, anxiety and panic may set in and all precautionary measures against unwanted pregnancy disregarded."

The already serious shortcomings in patient instruction shown to exist at many family planning clinics will soon become even more critical as these clinics expand their services to include abortion counseling, infertility services, sex counseling, sterilization and adoption services, Drs. Jacobson and Connell warned, adding, "the success or failure of . . . these newer programs may rest on the distinction and merits of their educational input." The Columbia investigators concluded: "A decisive effort must be made by each clinic director to formulate and implement a training program defining objectives and guidelines that will enable any health worker to successfully counsel any patient on her desired family planning goals. Concerning the teaching on the use of oral contraceptives this formulation of objectives is long overdue."

Source

L. Jacobson and E. B. Connell, "The Status of Patient Instruction and Oral Contraceptives: 1970," paper presented at ninth annual meeting of American Association of Planned Parenthood Physicians, Kansas City, Mo., April 5, 1971.

From Family Planning Digest 1:2 (1972), 13-14.

CHAPTER 28

Marketing the Innovation of Contraceptives to Post-partum Patients

Harry L. Levin, *Head, Information Programs, The Population Council, New York*

The maternity hospital ward full of women, all of whom are concerned very intimately with the birth process, offers an ideal setting in which to present a program to inform, educate, and motivate these women to adopt contraceptive practices.

From any point of view in the communication process, a relatively homogeneous audience which is confined, relatively immobile, physically inactive, sheltered from distractions, and that has time on its hands to consider, reflect, and introspectively meditate, is a unique group. All the individual's needs are being cared for by others and there is minimum intrusion from the family, neighborhood, or society on the receptivity level of the audience.

There has been much discussion, but little hard data, which would seem to suggest that women are most highly motivated to accept the practice of family planning immediately after delivery of a baby or after a miscarriage or abortion. If this is so, then the maternity ward would have that additional merit in its favor as a locale for motivating women to accept contraception.

From Post-Partum Family Planning, ed. by Gerald I. Zatuchni.

Women are generally tired after childbirth or miscarriage. It is reported that at this particular time they are intensely concerned about their own health and welfare and about the economic, social, and family future of any children that might have just been born. So the timing would seem to be right.

Perhaps another factor that suggests the maternity wards as an ideal locale for a program is the common experience that the entire assembled group is undergoing. Behavioral scientists and sociologists suggest that a common experience removes many of the barriers to an interpersonal relationship and breaks down more quickly than usual, normal reserve and shyness. This suggests a rapid identification by individuals with the group, as well as substantial socializing within the group. Thus, there would seem to be an opportunity for an easy and free relationship and exchange of ideas among the people on the ward.

To sum up, then, the special conditions that make for a favorable situation are as follows: (1) the prospective users are brought to the motivating agency—the customers come to you, so to speak; (2) the prospective users are brought together in a group situation; (3) the group is sharing a common experience; (4) the group is likely to be most highly motivated to accept advice, counsel, and contraceptive service during the hospital confinement; (5) there is little competition for attention; (6) the individuals in the group are relatively confined, sedentary, and are removed from the family and other distractions; (7) concern for their own health, welfare, and future, as well as that of the newly born, is great at this time; (8) there is great opportunity for intense exposure to family-planning messages, and since the locale is fixed the opportunity is ideal to use complicated hardware and delivery systems for messages—more so than might be able to be used in a field situation.

Some generalizations can be made about general strategies for a program that is designed to persuade people to accept family-planning practices. There are also others that are specifically related to a hospital-ward situation and that are unique to the post-partum situation.

As in any communication effort, it is usually a good idea to develop a program around a single theme. Many themes may be tried, and tests, trials, and experiments can be undertaken to find the best theme. The message should be direct, simple, and in the vernacular

of the target audience. This theme should have not only a visual, but also an audio identifying mark, symbol, or logo that should be used repetitively in the campaign.

A strategy to avoid is one which would try to teach the biology or physiology of reproduction to the audience. It is likely that the women are more interested in the "how" of practicing contraception than they are in learning the facts of life. If any lesson is to be learned from the advertising industry, it is the above. The detergent manufacturers don't explain in detail about the fat, acid, lye, etc., contents of their product, but concentrate on what their product does to make clothes whiter than white and to make the users' washday easier.

Any and all materials should be developed in such a way so as to inform, but whenever possible the presentation should be made in the form of entertainment. In view of the ward setting, there is likely to be little competition for attention during the confinement period, so this time affords a marvelous opportunity for getting a message or a series of messages across.

The fact that there is a confined and controlled setting in which the target audience is located also means that there is likely to be an opportunity to create an entire environment which is correlated with the delivery of information about contraceptive practices. Walls and ceilings can be covered with posters, murals, and other graphic material. Special attention can be paid to the placement of stickers, notices, and slogans in locations that are likely to get maximum attention, such as on menus, meal trays, clocks, mirrors, over sinks, on walls or partitions facing toilets, on nursery windows, on telephones, radios, and on TV sets, to mention some of the most obvious locations.

Other things that can contribute to creation of a total environment completely dedicated to the communication of information about family planning are such mechanical things as free-standing exhibits; programs, announcements and broadcasts over loud speakers, or over closed-circuit radio and TV; slide shows, movies,[1] pre-programmed tape recordings, nickelodeon-type machines that play and project presentations, magazines, pamphlets, leaflets, books, and covers with messages printed on them for all these items. The possibilities of presenting material with new-type hardware such as battery-operated slide machines, synchronized with tape-recorded sound messages, video tape recorders, etc., are too numerous to mention.

The hardware available for delivery of messages is increasingly more ingenious and innovative, and each program will have to analyze its own problem and devise the best solution for its needs from the selection of available equipment.

Besides the nature of the closed physical environment that opens up so many possibilities there is an additional unusual opportunity to educate, train, motivate, and use the staff on the ward as communicators, propagandists, promoters, and recruiters. The personnel on the ward are usually relatively static. Every orderly, helper, nurses' aide, nurse, doctor, social worker, clerk, porter, chaplain, in fact everybody who serves the patients or attends them is under the direct control of the hospital administration. The activities of each category of personnel can, and should be, analyzed to evaluate the type of contact that each has with patients. On the basis of that evaluation, decisions can be made about ways in which each category of personnel can be used to reinforce the message about family planning, and training programs can be instituted to prepare those personnel for action. To ensure performance, this activity can even be printed on the check list of requirements for personnel and can be built into such things as patient records to evaluate performance. For example, the admitting physician, in his examination routine, can use a structured chart that includes the reminder to ask specifically about the contraceptive practices of his patient. The discharging physician can be instructed on the forms attendant to departure, as to his responsibility to ask specifically for patient action regarding the acceptance of birth-control methods. The possibilities for other personnel participation are numerous, and each hospital should assess its own situation and plan accordingly.

One strategy that suggests itself above all others in a post-partum ward situation is that of utilizing successful contraceptive users from the group as group leaders in an organized effort to recruit others on the ward to adopt family-planning methods. As has been suggested above as part of the admissions procedure, successful contraceptive users can be identified. It is easy to visualize how these women can be held up as examples and how they can become the focal point of ward discussion groups, giving testimonials about the rewards of practicing birth control. People like to be asked for their advice; and people love to talk. One of the obvious advantages of utilizing this group is that these women are part of it and are sharing

the experience, so that their advice and counsel can be accepted as coming from a peer. Potential acceptors should be able to identify with their peers more readily than with hospital personnel or outsiders. This does not mean, however, that hospital personnel, outsiders, or important personalities should not be recruited in this effort. The efforts of any and all groups can be mutually reinforcing, and every effort should be made to do so.

Important personalities from politics, public life, entertainment, sports, and other fields of prominence and spotlight can and should be sought out for testimonials whenever possible. Advice from those sources, however, is not likely to have the same immediacy, impact, intimacy, or involvement as trying to get one of the group itself to act as a source of information. There is an added advantage in using members of the group, in that family-planning practitioners who are singled out and identified as "experts" in front of the others in the group will likely have a feeling of importance and a sense of status which in similar situations have often been powerful motivators for action. This idea is a theory around which the so-called "house parties" for selling china, cookware, cosmetics, etc., are organized. Millions of dollars of products are sold annually in this way, so that there is a basis for indicating that this is a successful technique and for recommending it.

It would be very desirable if peer groups could be organized on the wards in such a way as to have a continuing linking arrangement of newcomers into an already established group, so as to provide for an uninterrupted chain. In this way, the older members of the group can become the instructors for the newer members. As the early arrivals leave, the late arrivals become the instructors, and what is created is a continuous cadre group that is teaching itself. Some of the obvious advantages are that this is a peer group and at some point in time each individual succeeds to the status and role of "expert," teacher, and a somewhat exalted status. It might even be that a "buddy" system or a "Big Sister" concept can be employed to reinforce the impact of this type of approach.

In trying to create a situation involving total effort and total immersion, the opportunities for "face-to-face," and "one-to-one" confrontations are many in the hospital situation, as are the opportunities for group activities. The individuals should always be recognized as such, and every effort for persuasion should be personalized and individualized as much as possible.

It is important to remember to sell benefits in every message. The more immediate the benefit the better. People like to benefit "now" not "later."[2] Among the benefits that might be stressed in any campaign are the following: better health for the mother; better opportunities for the baby; happier married life and relations; more beautiful mother who is more attractive to her husband; economic advantages of small families; the mother is an economic asset and provider when she is a working mother; women's right to determine her own destiny and decide together with her husband when they will have the next child (spacing).

The messages should always stress the fact that family planning is safe, acceptable, reliable, reversible, popular, and utilized widely by the prospect's peer group. Every effort should be made to stress the benefits to the individual for practicing birth control, rather than for society or the country. It is important to try to develop answers to the question: "What is in it for me?" when designing a strategy.

Finally, although the post-partum program has been conducted in medical facilities and planned by a medical network working under medical auspices, it should be recognized that family planning or birth control is not entirely a medical problem or issue. It is indeed not even a classic public-health education problem. It really bears a very close relationship to a marketing problem for a product which is an innovation to a particular society. In this case, the innovation is contraception and the prospects are hospital patients, but it would seem to be useful to consider utilizing the best techniques from the marketing, advertising, and sales-promotion people in any program.

It might be useful to consider incentives such as baby photographs taken at birth which would be given to women who accept family planning when they return to the hospital for their six-weeks checkup. Free supplies might also be utilized as incentives and good marketing strategy would seem to indicate that every person leaving the hospital should be furnished with "take away" material which has some significance and value as a reminder or as a supplemental recruiting aid.

Direct mail follow-up can be used after hospital discharge, as can personal visits, and other techniques from the marketing manager's repertoire could and should be considered.

At some point in time somebody should be sure to "take the order" and directly ask each individual on the ward which form of contraception she intends to use on her discharge from the hospital. This,

again, is a marketing strategy that suggests that you offer a choice of behaviors, any one of which is acceptable, rather than asking the individual if she intends to undertake to adopt such behavior—"which" rather than "if." One offers a choice of something or something rather than something or nothing.

To sum it up, the maternity ward offers a substantial opportunity to turn a receptive audience into contraceptive users.

NOTES

1. See Appendix D—Population Council Films List.
2. The Direct Mail Advertising Association lists 25 widely accepted buying motives:

For comfort.
For cleanliness.
For health
For praise.
To be popular.
To attract the opposite sex.
To avoid trouble.
To protect family.
To emulate others.
To save time.
To avoid effort.
To save money.
For enjoyment.
To gratify curiosity.
To be in style.
To assuage pain.
To conserve possessions.
To make money.
For beautiful possessions.
To satisfy appetite.
For safety in buying.
To avoid criticism.
To be an individual.
To protect reputation.
To take advantage of opportunities.

ARE WE, THE FAMILY PLANNING COMMUNICATORS, IGNORING OUR MOST IMPORTANT AUDIENCE?

by
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Community and Family Study Center
University of Chicago
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Are we, the family planning communications experts ignoring the most important audience of all? And if so, what are we going to do about it?

We who spend our time and talents in the communications field have learned to approach most of our problems in a very special way:

> "Who," we say, is the audience?
>
> What does he (or she) want or need to know?
>
> How can I find out?
>
> What am I going to do about it--in terms of developing clear messages for dissemination in appropriate media?"

And we look for all the audiences, but think of them in terms of many "he's and she's" for we know there is no "mass audience"--only a lot of individuals making important personal decisions one or two at a time.

This should be especially true in an area such as family planning. But "family planning communications" as such is really a new field, forced into existence by the unprecedented skyrocketing into prominence of population as a major problem, increased concern over possible answers, and acceptance of a hitherto taboo topic as a partial solution. For valid crisis-oriented reasons therefore, emphasis has been on theories of mass communication, factors in effecting behavioral change, establishment of programs and departments to implement them--and more.

But now as it is all getting sorted out, it would seem that around the world one audience of number one importance has somehow been overlooked, discounted as being in the domain of others, lumped with other audiences or "fallen into the cracks."

I'm talking about clients in service-providing situations--and to overlook them doesn't make sense--because here is our ultimate audience brought to a crucial decision making point in their lives--and we ignore them.

We have developed community acceptance, at least in part; we have recruited these women (and men) to our clinics; we have followed the communications theories in that we have:

> created awareness
> built interest--even persuaded them to try

as evidenced by their coming to the service dispensary. It is up to us to see that

acceptance

positive evaluation

and adoption

take place.

It doesn't make sense. We have individuals who, knowledgeable or not, are positive, negative, enthusiastic, apprehensive, curious, nervous, or any combination thereof as they enter the door where we offer services. In effect we invite them in then, bid them "goodbye" and, when all the specific skills of the communicator are most needed, turn them over to a staff medically, not communications, oriented and expect them to emerge satisfied continuing "acceptors."

In truth by so doing we run the risk of "the medium becoming the message" in the voice of the hurried brusque doctor who speaks in "medicalese," the unprepared nurse, the impatient receptionist intent on gathering statistics--and we lose that woman for all time. To underscore the results of our oversight--the dropout figures in most clinics clearly indicate that the support necessary to assure continuation of the method is not being provided. Else why are they so high? Better than counting "acceptors" for those ubiquitous statistical charts we should learn to count "happy continuing patients" still with us as after an appropriate lapse of time, perhaps a year.

There is no question but that the "in-house," in-clinic, in-dispensary, education or whatever you want to call it, has been the bailiwick of the medical personnel so long that any effort to change it may well be considered a threat and will need to be approached with real finesse. The historical reasons for this no longer matter; what does matter is the need to professionally redo the educational process. A real test of the public relations/communications abilities of the communicators may well emerge in his or her ability to sell key officials, program officers and medical personnel on the need for a carefully designed communications component built into the budget as an essential part of the service on an equal basis with medical care!

But whatever the preliminaries necessary for involvement of the special abilities of the trained communicator may be, they are essential to the real success of the total program and need to be pursued.

Having laid the groundwork, let's proceed to look at what an encompassing plan for "client education" might include:

> First--what is the objective of well-designed comprehensive client education? If we can begin by agreeing that one objective is "to provide the individual with information and support so that she will choose a method of contraception, use it correctly with comfort and assurance and, to that end, maintain a continuing relationship with the clinic"--we have a beginning.

Obviously this definition would need to be edited a bit for the woman on the post-partum ward--or the man in the vasectomy camp--but the intent and the product remain the same to assure a "satisfied client."

Which brings us, almost as an aside to a look at the term "client" education as opposed to the more often used "clinic" or "patient" education. The latter two have a special connotation of medicine and illness which add the negative emotion of fear to the many other barriers. The term "client" has an element of dignity and implies a continuing relationship which we want to encourage.

For client education, properly designed should be a process occurring over time, beginning where the individual is and proceeding with involvement by her (or him) so that decisions can be made and action taken based on personal goals. It is not, obviously, something that can be encapsulated and offered on a one-shot basis.

Client education, in other words must be carefully conceived and faithfully executed. It must not be a sometime service fitted in an offhand manner--if time permits--into the delivery of the method.

The concept needs exploration and serious consideration taken of the many components--to name only a few:

--the setting

--the personnel--their training and their attitudes

--the messages

--the necessary supportive materials

--the barriers, physical, mental, psychological not only on the part of the patient but built into the delivery system...

--many many more

It is important to take an overall look--to paint a total picture with a broad brush--so that a working viable program can be developed. In order to do this we must begin by asking questions:

Maybe even ask "WHY?" Isn't providing what is obviously a wanted and necessary service enough? No. Provision of service means only that we are willing to content ourselves with a dispensary action--in effect provide a "band-aid." Our stated

goals are really to effect behavioral change. Medical service with education at the point of service encourages understanding and promotes continuing responsible use. Ideally, coupling the latter with preliminary information and continuing support can result in the kind of permanent behavioral change which allows achievement of some important personal goals.

The questions we can help pose--some of them. The rest, and certainly the answers will have to come from you working out there seeking to build the kind of program which will assure a continuing relationship with a satisfied client.

For instance:

Where should client education begin?

Where is it offered?

Where should it be?

In the waiting room?

At the interviewer's desk?

By the doctor during the examination?

On the post-partum ward?

At the mobile unit?

Vasectomy camp?

?????

What about the setting?

Are the facilities:

Pleasant?

Warm?

Colorful? Private?

Who is the audience? Specifically.

What does she/he want to know?

We are concentrating on specific audiences in a particular setting, and cannot overlook the need to know as much as we can about each individual. To make whatever we design successful we need to get input or feed in from the members of this audience and those who know about them. This information needs to be medical, demographic, and most important, personal, to find out where at this point in time this client is.

Talk to the field worker who spends her days promoting family planning. What are the concerns and questions she deals with?

Talk to clinic personnel. What do they see as the essentials? What help would they like? What topics do they see as important?

And for Heaven's sake talk to the clients! Satisfied ones--and disgruntled ones if you can find them. What do they want to know? What information are they getting they can do without? What are their fears? What is the community saying about family planning?

Who is the communicator? Better, who are the communicators? Because communication, good or bad, positive or negative, takes place every time the client and a member of the staff make contact. "Education" takes place at every step--and the total message with which the patient goes home needs to be carefully divided among these steps--so that the effect is cumulative and more effective.

So, who delivers what part of the message? Is she/he warm? friendly? judgmental? trained? able to develop rapport? How can these skills and attitudes be developed?

What are the barriers to effective communication? Some are surprising. The list can be almost endless, but a careful analysis can prove valuable.

overcrowded clinics

lack of time to establish one to one relationship

overburdened staff

awe of communicator--inability to ask questions

lack of privacy

status consciousness between doctors and staff

and between clients and service personnel

illiteracy

relationship of family planning to husband/wife

rumors

attitudes about sex

fears, doubts, misconceptions

religion

taboos

relationship to economic and social considerations

mind on other subjects

poor visual support materials

or other materials

How good are the support materials available?

Do the visuals relate to the experience of the audience?

Are they easy to understand? Colorful? Interesting?

Are they localized?

Is the necessary "hardware" available, accessible, easy to operate?

Are take home print materials easily understood? Could the clients be involved in planning more effective ones?

The whole concept of client education as a responsibility and concern of the communications specialist is too new for us to have touched all the areas or even explored all the problems and possibilities. But questions need to be raised and answers diligently sought.

What now?

Identify in our own programs the facts and figures which give an index of the effectiveness (or lack of same) of whatever supportive education we are offering in our clinics.

Analyze in our own service settings the educational process with particular attention to the gaps which might account for high drop out and failure rates.

Use the above facts to justify assigning client education an important role in total program development if it warrants it with the appropriate budgetary allocation to assure proper staffing, training, and materials development.

Assign to proper staff the design of workable pilot projects.

Insist that input on content and materials be obtained from those whose opinions are most valued: fieldworkers, clinic personnel--the clients themselves!

Build into training for clinic and hospital personnel the knowledge and attributes necessary to perform their jobs properly.

Urge the inclusion of a unit or client education as a part of the training of all communications personnel.

Upgrade the content and quality of support materials used in clinics and other service delivery setting to assure their suitability.

Of course this list is just a beginning--you take it from here.

If you subscribe to the very basic model

you can see all the components are in the service setting. We, the communicators have a professional responsibility to see that the model is built of the very best materials so that the arrow really "hits the target."

BELIEFS, CHANNELS AND THE FAMILY PLANNING MESSAGE

THE DOMINICAN REPUBLIC

A Project Report

Presented to the Department of Communication Arts

of Cornell University for the Degree of

Master of Professional Studies

by

Eleanor Elizabeth Glaessel

December 1971

ABSTRACT

Population/family planning have rapidly become worldwide concerns. As in most Latin American countries, the Dominican Republic has witnessed a flowering of family planning clinics throughout the country. Yet the number of women entering the clinics has decreased as the program continues.

One factor inhibiting women from enrolling in the clinics may be the commentary they hear in their neighborhoods. The present study was undertaken to discover what information is circulating about the contraceptive methods offered in the clinics, through what channels family planning information flows, and what techniques clinic personnel use to combat the negative and enhance the positive commentary. A sample of 150 active clinic users and 50 dropout, or inactive, cases was chosen from a group of women to whom an interview schedule had been administered. In addition, staff members in eight clinics were interviewed.

It was found that positive and negative commentary concerning the intrauterine device and the contraceptive pills (the two most frequently used methods) were more related to health considerations than to convenience-, pregnancy-, husband-, and mechanical-related concerns. The respondents would give positive advice to other women about both methods: 55 percent for the IUD and 74 percent for the pills. Medical professionals (doctors, graduate nurses and nurse's aides) were accorded the highest credibility of all available information sources; 58 percent of the respondents would seek their advice about family planning matters. Women converse about family planning most frequently with friends and neighbors (56 percent), less often with relatives (13 percent) and almost not at all with their spouses (0.8 percent). Clinic personnel believe that visual demonstrations and simple comparisons with easily recognizable objects and events are the most effective techniques for educating clinic users.

It is recommended that the clinic be used as a base for community family planning education. An intensive education and information program could be provided for clinic users during their regular control visits and at no extra cost to the program. Techniques tried by clinic personnel should be tested for effectiveness and combined with messages that relate to the experience and concerns of the audience. Well-informed clinic users could then become agents of accurate family planning information in their neighborhoods.

CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

The purpose of this project was to collect information to enhance family planning communication strategy in the Dominican Republic. The objectives were to find out what commentary clinic clientele hear in their neighborhoods and through which channels, and what approaches clinic personnel have found to be effective in teaching about family planning. The following points can be summarized from the preceding discussion.

Because family planning is a subject based on conflicting social values and practices, messages related to its adoption might be distorted by target audiences. Much of the negative commentary is based on method side-effects and confusion is increased by ignorance of simple reproductive physiology. Without inputs of accurate information, women remain afraid, confused and insufficiently motivated to visit a clinic. The radio, although it can create awareness about the availability of family planning services, is unable to address the questions which most concern the public--how do the methods actually work and are they harmful. One motivator noted

> She called me to her . . . she had twelve children, is very poor earns little money. She always heard the radio announcing (family planning) but she says she needed someone to explain it to her well.

Interpersonal channels of communication are considered more effective in persuasion communication than the mass media.

One of the purposes of this project was to discover what is being done to combat negative commentary about family planning and the contraceptive methods. Some communication techniques have been tried in the clinics, but little is being done in the communities. The Dominican family planning program does not have a comprehensive mass media family planning campaign. Word-of-mouth communication, then, becomes more vital as a channel to inform women of the program and to direct them to the available services, as well as to persuade them to adopt family planning. That diffusion of family planning information through informal channels is considerable has been shown in several countries.

Popular commentary about family planning methods was grouped into the following categories: health-, convenience-, pregnancy-, husband- and mechanical-related concerns. Health-related concerns were mentioned most frequently about the intrauterine device and the contraceptive pills, and mechanical-, pregnancy- and husband-related concerns were cited most often about the foam and

condom. The respondents would give more positive than negative advice about the methods to other women.

Data about the channels of information and source credibility show that family planning information is primarily learned in the clinics. Graduate nurses have the highest credibility of all sources of information tested; doctors are a close second. When seeking advice about family planning, women have more confidence in medical personnel than in their friends, relatives and neighbors. Interaction related to family planning is high among neighbors and friends, less intense among family members and very low between spouses.

The literature suggests that clinic users enjoy high credibility in their neighborhoods because of their socioeconomic and educational similarity to barrio[1] women and because of their personal experience with the clinic and contraceptives. As users they are knowledgeable about and sensitive to the topic. As neighbors, friends and relatives they are readily accessible, although some might be less inclined to talk freely about family planning than others. These women can be bearers of both positive and negative information, most likely reflecting their own experience.

The communication situation in the clinics is favorable for an I & E program. Each day small groups of women form in the clinic. At least one strong common interest, family planning, is held by the group. A member of the clinic staff engages in face-to-face interaction with the women, enabling her to gauge comprehension and correct misunderstanding.

Techniques have been developed, although not tested, by some clinic personnel to counteract popular negative commentary and to make in-clinic I & E more appropriate to the understanding of the average user. The techniques fall into the general categories of verbal arguments, visual demonstrations without equipment and simple comparisons.

RECOMMENDATIONS

1. The clinic ought to serve as a community family planning education center. Not only should it provide I & E and medical services to women who present themselves at the clinic doors, but it should also stimulate these women

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[1] Barrio: The term for "neighborhood" in a Dominican city or town; often with the connotation of a slum or low-income area.

to act as information agents in their barrios and campos[2] and reach out to the community. There are a number of levels on which this could be done. Least ambitious would be a simple altering of the conventional charla[3] to include a section stimulating the audience to act as individual agents of accurate family planning information in their neighborhoods. This plan could be made more systematic by encouraging informal promotional work. For example, each clinic visitor would be issued a coupon after, say, her fourth visit and after hearing a sequence of four educational charlas. She would then "qualify" to teach another woman about family planning and give her the coupon to turn in upon enrolling in the clinic. (Incentives such as soap or aspirin might be given to the client motivator for each new acceptor she sent to the clinic, however the writer is not in favor of that practice.

On an even more formal basis, regular motivational and education programs might be offered. This could be a combination of in-clinic and community I & E. For instance, a series of family planning information and education charlas using audio-visual aides and group discussions could be developed as a unit. They would constitute somewhat of a Family Planning Short Course. One use for such a unit might be a more organized means of training selected, interested clinic users as family planning information agents and motivators. They would be given a certificate or emblem upon completion of the course. Another use would be to present the series over several days in such locations as the clinic during non-clinic hours (noon-2 p.m., evenings, Saturdays), at community centers or even in private homes and backyards. In this way males might be reached by either inviting couples to attend the showings or by providing exclusive male sessions. (Evidence indicates that the latter would be more successful because attention is distracted if both sexes are present.[4]) Once developed and learned, the I & E unit could be easily managed by clinic personnel and would involve only four extra hours of work a week for one person whenever the series was presented. The first two methods of improving I & E suggested here involve no extra input beyond altering the conventional charla and providing coupons.

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[2] Campo: Refers to the countryside or rural areas of the Dominican Republic.

[3] Charla: A short, informal lecture or talk. The type of charla referred to here is the brief orientation lecture given to women, either in groups or individually, in most family planning clinics in the Dominican Republic.

[4] Stycos and Bach, The Control of Human Fertility in Jamaica.

2. Related to, but not dependent on, the first recommendation, it is suggested that clinic personnel be periodically given I & E refresher courses. Clinic personnel who present the charla ought to be trained to exploit the favorable communication situation of the clinic. They should be instructed in group dynamics to involve the listeners in a discussion, learn expressions and methods that have been proven successful and watch for clues that indicate understanding. They should also be given the opportunity to ask questions about confusing points of method use and side-effects. Refresher courses could be conducted at the Ministry of Health and include role-playing practice charla presentations with clinic staff members from other clinics participating with helpful observations, criticism and suggestions from their own experience.

3. All clinic I & E discussion sessions should concentrate on topics related to the experiences and needs of the users and use language and expressions comprehensible to them. A meaningful educational experience is the most important service a family planning clinic can offer next to the contraceptive device itself. Ideally, the clinics should eventually have mastered I & E techniques enough to be able to offer a wide spectrum of maternal-child health information. Suggestions for a model conventional charla, based on the findings of this project, are presented after the last recommendation.

4. The charla might be dramatically altered by the use of audio-visual aides. (Clinic rooms are rarely appropriate for audio-visual equipment during clinic hours. This discussion is therefore limited to the I & E special units suggested in the second recommendation, to the few clinics where the situation is favorable or to the possibility of locating improved charla quarters.) A ten-minute film or recording of a charla given by a graduate nurse or doctor might be presented and followed by a ten-minute discussion and question period. This would avoid the boredom of repeating the same charla day after day, would require that a clinic staff member be released from clinic duties for less time and assure that the topics of interest and questions of a particular audience would be covered.

Discussion and/or question and answer sessions among clinic users and high level staff members could also be used as stimulus for either in-clinic or community courses and family planning personnel training courses.

5. Medical professionals, especially graduate nurses and doctors, should be used as information sources in messages that involve technical information.

The following spot announcements should bring results.

VOICE OF BARRIO WOMAN: "Dr. Fulano, what is family planning?"

VOICE OF DOCTOR: "Family planning is a way to have children when you want them. It is good for your health and the methods are not harmful. Why don't you go to the clinic?"

VOICE: "You went to the family planning clinic? Weren't you afraid?"

VOICE: "No, little sister, it is not harmful, and this way I can wait a few years before having another baby."

SUGGESTIONS FOR A MODEL CHARLA

I. Conduct the charla in an informal, friendly and lively manner.
   A. Create a friendly atmosphere to ease the minds of those who are uncertain, preoccupied or anxious about the impending physical exam.

II. Ask questions to indicate what the listeners have heard and what concerns them.
   A. What is family planning.
   B. How many children does each woman have.
   C. Do they have family or friends who are planning.
      1. What have they said about the clinic and the methods.
   D. What methods does each woman intend to use and why.

III. Discuss family planning, the clinic and the methods on the basis of commentary that the women have mentioned. For example, if a comment such as "The pills (IUD) make you gain weight" is made, use the opportunity to explain that slight weight gain might be caused by the pills, but most people gain weight because they are more relaxed (not having to worry about pregnancy) and possibly healthier (having rested from repeated pregnancies.
   A. Stress the fact that the methods are not harmful to their health. There are women who are unable to use some methods, but others are available.
   B. Use both the scientific and the local word for a method or organ. That way the audience knows what is being discussed and might learn to associate the technical term with the colloquial reference.
   C. Include both the positive and negative aspects of the methods in the discussion, plus a full description of the possible side-effects.
   D. Keep the explanations simple and clear.
   E. Use comparisons with everyday things that the audience can clearly visualize. (These would have to be devised for each clinic.)
   F. Spend a few minutes discussing the male view of family planning. This could be initiated by asking the group what they believe men (their husbands) think about family planning. The discussion could be directed toward trying to understand the different positions men take on contraception and finally toward pointing out the advantages of spaced child-bearing for the family and for

husbands in particular. This might assist women in discussing the topic with their spouses.

IV. If it does not emanate from the discussion, explain the internal organs and their respective functions, emphasizing the digestive and reproductive systems. Point to their location in the body or use a full form cardboard figure with the organs clearly drawn.

V. Pass the IUD, pills, foam and condom around to each woman so that they can be examined.

VI. Make a continuous effort to involve the audience in discussion, instead of simply lecturing.
   A. Ask for questions after each topic because they might be forgotten by the end of the charla.
   B. Do not attempt to cover more material than the group is able to grasp. Be satisfied with a few points well understood.
   C. Prepare the listeners with arguments that can be used to combat negative commentary circulating in the barrios and campos.

VII. The charla should not exceed 20 minutes because the audience is saturated by then and the clinic flow would be disturbed by a longer session.

VIII. Review and repeat the basic points covered during the discussion by asking questions and filling in where answers are weak.

IX. Distribute take-home pamphlets, including at least one directed at male audiences, and suggest that they be distributed among friends and relatives.

FURTHER STUDY

The findings of this report suggest areas for further study. Family planning beliefs, concerns and communication networks of non-clinic users should be studied in an attempt to discover what commentary circulates among people who have had no exposure to the clinics, and what would be the most effective methods of approaching women in this group.

The effectiveness of the present charla must be studied in depth. Then the impact of message units including examples of popular commentary and concerns, visual demonstrations, verbal arguments and comparisons and audio-visual stimuli could be compared with the information clients absorb using the present method. Related to such a study is the evaluation of a number of different techniques for presenting the charla.

The feasibility of training clinic personnel to become dynamic communicators and an evaluation of the accuracy and flow of information circulated by barrio agents should precede all recommendations to use the clinic as a training base for user community educators.

Perhaps with the refinements of experiment, study and practice, family planning communication will ease the minds of more men and women, encourage more couples to adopt contraceptive use and help them through periods of uncertainty to care-free and continuous family planning.

CHANNELS	ARENA OF ACTION	MEDIA	CHARACTERISTICS & KNOWN EFFECTS	LIMITATIONS	SUGGESTED USE
1. SOCIAL STRUCTURE	A. MICRO-COMMUNITY-OF EXISTING SOCIAL RELATION-SHIPS	(1) WORD OF MOUTH	(1) Research shows word of mouth is the most effective means for making fundamental changes in strongly held attitudes and of affecting behavior The effectiveness of change is conditioned by the degree to which the hearer subscribes to the speaker. This is the second step in what researchers in communication call the two step communications process.	(1) Must work within the limited range of existing social relationships. The process must be generated many millions of times to penetrate the great members of micro-communities where interpersonal influence is most intense.	(1) Because of its demonstrated effectiveness in changing strongly held opinions and moving people to action word of mouth communication within the existing social structure is one of the most important media that must be used in spreading family planning practices. It is specially important in persuading people to try contraception and in solidifying acceptance into adoption.
		(2) ACTION EXAMPLE	(2) Actions speak louder than words. The action of a couple located near the top of the prestige scale within a social group, caste or stratum is a potent influence on the behavior of the members of that group. The act of adopting a contraceptive method, if it is known, can be highly effective in getting others to adopt.	(2) The limitations cited for (1) above hold for this medium also. Further it is not necessarily easy to get people to make known what they have done in this very personal area of living.	(2) Within the limits of what is permitted or accepted by the people involved those who have acted to adopt a method should be persuaded to tell their contemporaries what they have done and why.
		(3) SATISFIED PRACTI-TIONERS	(3) Provides a vicarious "trial" stage in the adoption process that may move the related observer toward overt trial, acceptance and adoption.	(3) As the limitations cited in (1) and (2) above, but is so important to achieving minimal critical mass for adoption in a group that all satisfied practitioners should be identified and persuaded if it is required, to let others know. This is closely tied up with the whole personal influence equation in the social situation.	(3) See (2) above.

*Underlining emphasis has been added to focus on client education by module authors.

CHANNELS	ARENA OF ACTION	MEDIA	CHARACTERISTICS & KNOWN EFFECTS	LIMITATIONS	SUGGESTED USE
2. EXTENSION SYSTEM →	A. *FAMILY PLANNING CENTERS, HEALTH CENTERS, HOSPITALS, ETC.*	(1) INSTRUCTION WITH SERVICES USING REAL THINGS AND BODIES	(1) Family planning services are also a medium of communication, the way they are organized, the attitudes of the staff, the spirit in which the service is given, all are a part of this communication. The teaching mission and effect of every action in the service institutions should be carefully planned. This medium of communication is personal, individual, and when properly done is highly effective.	(1) The work of the services can begin only after people are well along in the adoption process and have been motivated to come to the center. Other activities and other media have to have done their work first to get the people into this arena of action.	(1) The organization and operation of the services in family planning will consume an important position of the whole effort. Their communication effects should never be lost sight of. Done badly they can dampen the spread of FP. Done well they will rank as among the most effective means of spreading the adoption process.
		(2) PICTURES & CHARTS	(2) There are many aspects of the reproduction process and of the use of each method of contraception that cannot be fully made clear using real things and bodies alone. Most of these limitations can be easily overcome with a well selected set of pictures and charts that are systematically used in teaching clients somewhat more than the bare essentials.	(2) The pictures and charts must be simple and uncluttered. A large percentage of clients will not be very skilled in interpreting the type of exploded or cross sectional representatives that should be used. Both the way in which the graphics are prepared and used should keep these audience limitations in mind. A careful gauging of the amount of "over teaching" that is to be made should help to determine content and quantity of pictorial teaching aids.	(2) A well planned and carefully ordered set of pictorial teaching aids targeted to help deliver specifically determined learning results should be a part of every family planning services center. Staff should be trained on how to use these materials efficiently. And their continued use of them should be a specific supervisory responsibility to insure that use is not inadvertently discontinued.
		(3) MODELS	(3) There are a number of kinds of models that may be used with great effect. They range from rather simple anatomical types that show significant organs and their relations in three dimensions to very elaborate models that	(3) They are likely to be fairly expensive and will take both space and care to keep clean and in good condition or working order. However the expense can be kept within reason if a central production shop is	(3) Not necessary for a beginning but probably should be kept in mind as a goal of development as programs mature.

			show all the major events of the menstrual cycle. These latter were developed and widely used in Japan. Models are frequently more easily understood than flat drawings particularly by people with limited schooling.	developed for a national FP Program.	
		(4) PAMPHLETS	(4) Every center should have a set of carefully designed pamphlets to be used as take home pieces by clients. Printed matter that is not too expensive is very effective as a reminder to clients on both the reasons why FP should be practiced and to remind them of detailed steps in procedures. If they are put in picture dominated form they will communicate even with the illiterate.	(4) The biggest limitation on pamphlets is the widespread illiteracy that is characteristic of many of the audiences that need FP. If put together with pictures that present the whole message along with printed words much of this limitation can be overcome.	(4) Each family planning center should have several pamphlets designed to match the adoption stages. Those that are designed to reach people in the early stages can be used by clients in the later stages to tell their friends about the center and its work. The pamphlet becomes a good excuse to start talk. Those for the late stages serve as reminders in the techniques of contraception.
	B. HOME VISITS [OR IN-CLINIC USE]	(1) FLIP-BOOKS	(1) Home visits by paid workers or volunteers can play an important role in many FP programs. Small size flip-books can be extremely useful to the home visitor in presenting both the general information about and the reasons for FP, and in explaining the just how one or more specific methods work. In sizes 10 by 12 to 12 by 14 inches they can be used with an audience of 5 to 10 people.	(1) The planning and production of flip-books takes a good deal of effort and good graphic art skills in making and reproducing the necessary pictures and text. They sometimes are difficult to carry and protect from the weather, and so must be designed with the mode of transportation of the visitor in mind. Initial cost can be a drawback but if well done and properly used will be worth the cost and effort.	(1) Would strongly recommend their production of suitable flip-books covering a number of subjects that home visitors need to cover in FP programs. This aid can be especially helpful in getting volunteers to the point they are willing to make home visits and in guiding them on the points they need to touch upon in talking with those they visit.
		(2) FLASH CARDS	(2) Flash cards small enough to fit into a purse and carrying only the minimum of pictorialized information are	(2) Flash cards are easy to get out of sequence particularly if there are a number of them in the	

CHANNELS	ARENA OF ACTION	MEDIA	CHARACTERISTICS & KNOWN EFFECTS	LIMITATIONS	SUGGESTED USE
			another useful home visit teaching aid. They can be used with 2 or 3 people at a time. Small, easy to carry.	set. Not so useful to the volunteer.	option to be kept in mind.
		(3) DEMONSTRATIONS	(3) Demonstrations, when they can be used, are highly effective teaching media. The home visitor can demonstrate the various FP devices that are used in several contraceptive methods.	(3) Large demonstration devices cannot be easily removed for home visits. Showing the devices so that people become familiar with them is about the limit in home use.	(3) Home visitors should be equipped with a set of the appropriate FP devices and should develop skill in showing and explaining them.
		(4) PICTURE DOMINATED PAMPHLETS	(4) Picture dominated printed matter is highly useful. They are picture dominated when the essential message is contained in a series of sequenced pictures that can be understood without reading. Very simple, limited captions. Are especially useful with the untutored. When left with those visited serve to continue the learning process. Should be designed to fit the appropriate adoption stage.	(4) If not carefully designed and fully pretested may be misunderstood by the illiterate. Will cost time effort and money.	(4) Because pamphlet stays in home and continues to remind and stimulate discussion well worth cost. Home visitor should be equipped with ample supply of a set designed to each adoption stage.
		(5) WORD DOMINATED PAMPHLETS	(5) Word dominated document is one in which the major communication information is carried in words with only a few illustrations. With well educated audiences this type of printed matter may be superior because the reader may resent the oversimplicity of picture dominated printed matter.	(5) Not useful with bare literates and untutored. Should be written in clear, simple style even for highly educated but should use the vocabulary that the audience respects as denoting an educated person.	(5) Much of the printed FP literature already falls in this class. In many cases it could be improved by following the guidance given in "How to Improve Written Communication for Birth Control" by Bogue. Revised or new materials should be pretested to determine level of audience and effectiveness before printing.

C. TUTORIAL & SMALL GROUP INSTRUCTION	(1) FLIP-CHARTS	(1) Flip-books with page sizes up to 25 or 30 by 30 to 40 inches are excellent teaching aids for formal tutorial or small group instructional situations. They should be heavily pictorial and very carefully sequenced. They can carry text for the students to see and can have prompting material on the back of the proceeding page for the instructor. Particularly useful in supporting and guiding the poorly trained or volunteer instructor.	(1) Cannot be seen by too big an audience but at page sizes noted if heavy lines and large letters used and each picture kept simple up to 40 or 50 people can see clearly. Must be packaged for carrying and showing and to protect from rain. Will cost. Can be produced by silkscreen process.	(1) Flip-books do not require a darkened room or any projection equipment. They may well be the picture dominated teaching aid of choice for use in rural areas. If [illegible] they should be fully [illegible] and then produced in enough quantity to have wide use in the program. Users should be trained in their use and supervised to improve use technique.
	(2) FLASH CARDS	(2) Large sized flash cards can be used. The principle difference from a flip-book is that they are not bound in a fixed order so the instructor can vary the order if he desires. See (1) above for size indications.	(2) Flash cards have the disadvantage of not being as easily handled as a flip-book when large page sizes are concerned. They have to be made on heavier card stock to stand up alone and can be gotten out of order.	(2) Would not recommend them over flip-books in most situations, though in special situations and used by an instructor who prefers them. They have to be listed and considered as possible aids.
	(3) SLIDE SETS (COLORED OR BLACK AND WHITE)	(3) Where electric power and slide projectors are present sets of slides, either black and and white or colored, can be extremely effective in teaching. The selection sequencing and writing of commentary are all steps that require care and some skill to produce the most effective teaching unit. Matched to a recorded tape a set of slides can be made to perform much like a motion picture film.	(3) Require electric power and projection equipment and carefully designed and executed production plan to make a set that teaches well. Also need a darkened room unless rear screen projection used. Slides can get out of order and lost, but can also be rearranged or used in an order.	(3) Slide sets are strongly recommended for many types of technical instruction of full time personnel in FP programs. They can also be used in training community leader volunteers as well as the public in towns and cities where power and space is available.
	(4) FILM-STRIPS	(4) Filmstrips with carefully programmed sequences of pictures and well written instructors guides are proved excellent teaching aides especially for use by poorly	(4) Require projection equipment, power supply and suitable area where light can be controlled or a rear screen system is available. Also require	(4) Any national FP program should plan to develop the capability of designing filmstrips and in most parts of the world the actual production can be done in

CHANNELS	ARENA OF ACTION	MEDIA	CHARACTERISTICS & KNOWN EFFECTS	LIMITATIONS	SUGGESTED USE
			trained or volunteer instructors who have uncertain mastery of the subject matter that is carried in the filmstrip. Such people must be taught how to use the filmstrip.	properly produced filmstrips. However the production of filmstrips is not nearly so complicated or expensive as producing films and the instructional effects in many cases is even better.	government audio-visual centers or there are private groups that can produce on contract. The proper equipment should be acquired and a consistent plan to use this excellent instructional tool be put into effect.
		(5) MODELS	(5) There are many models that are excellent for small group instruction. They are particularly useful in teaching sex anatomy and the birth process.	(5) Limitations are cost, bulk, for transportation and the limited types of subjects for which they are essential to get the information across.	(5) Models should first be used in the instructional programs at the FP agency's centers and then used with the public as program develops and opportunities arise.
		(6) DEMONSTRATIONS	(6) See B, (3) above.	(6) See B, (3) above.	(6) See B, (3) above.
		(7) PICTURE DOMINATED PAMPHLETS	(7) Picture dominated pamphlets are excellent "take away" pieces to use with many group instructional programs. They continue to remind the trainee of the content after the class is over.	(7) See B, (4) above.	(7) See B, (4) above.

A GUIDEBOOK
for
FAMILY PLANNING EDUCATION

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III. SELECTION OF METHODS AND MATERIALS

If the last section helped you state your objectives in terms of your audience and the desired behavior, then specifying activities and functions follows naturally.

There are so few reliable studies or guidelines on how to achieve your aims, and there are too many variables in each situation to be able to come forth with precise program recipes. Thus, this section can help you create the conditions for the highest probability of success and suggest alternatives in case your first selection does not prove out.

Table 1 contains a rating of the various types of methods and materials available in terms of efficiency, effectiveness, and convenience. The rankings run from a high of 3 to a low of 1 and assume the optimal application of the method or media. If, for example, a staff person has not developed the art of listening and interacting, face-to-face contact can fail to fulfill its potential and become one-way communication.

As you review the table, it may be useful to picture a specific method or material in terms of the location in which it is to be used. For example, the clinic which is big, busy, and crowded or the church where you bring in your own equipment are both quite different from the hospital sun porch where there is no wiring or from the storefront clinic where trucks rumble by. Each of these locations has its own physical characteristics which will affect your choice of communication method.

Next it might be useful to consider the individual staff members in that particular location. Are they comfortable in an informal discussion in which people can feel free to sit on the floor? Can they manage a projector smoothly or does their uneasiness in such a situation distract the audience? Or, conversely, do they need something to occupy their hands to feel at ease? Are they good speakers? Are they able to detect that unexpected "teachable" moment and use the opportunity to the fullest?

These are some of the realities which should be considered before assessing a method's intrinsic effectiveness and efficiency. The reason is that no method is worth expending resources on if it is not workable in the situation at hand.

TABLE 1

RATINGS OF THE VARIOUS METHODS AND MEDIA[a,b]

	Method, Media/ Materials	1 Situational/Convenience Factors			2 Efficiency				3 Effectiveness											
									Characteristics							Teaching Objectives			
		Time Required of Audience	Staff Involvement	Special Space (Sound/ Light) Required	Initial Costs	Labor Costs		Amount of Space	Equipment Repair/ Replacement	Interaction	Attention/Interest				Pacing		Facts	Procedures	Principles/ Concepts	Attitudes/ Opinions
						Initial	Ongoing				Light	Color	Motion	Identify	Retention	Repetition				
A	Visual																			
	Still pictures, posters, transparencies, photos	1	1	1	1	2	1	1	1	1		3		1	2	1	2	2	3	1
	Stills in sequence: bulletin boards, flip charts, exhibits	1	1	1	1	2	1	1	1	1	1	3		1	2	2	2	2		1
	Mobiles	1		1	1	2	1	1	1	1		3	2		2		2			
	Print: pamphlets, handbills, newspapers	1		1	1	2	1	1	1	1		2		1	2	2	2	2	2	2
	Programmed learning	2	1		2	2	1			2		1		1	2	1	2	2	2	2
B	Audio																			
	Tapes and records	2	1		2	2	1	1	2	1				1	1	1	2	2	1	2
	Radio	1	2	2	2	1	1			1				2	1	1	2	2	1	2
	Telephone	2	2	1	1		2			2				1	2	1	2	2	1	2
C	Audiovisual																			
	Filmstrips and slides	2	2-1	2	2	2	1	2	2		2	2	2	1	2	2	2	2	2	2
	Movies	2	2-1	2	2	1	2	2	2	2	2	2	2	2	2	1	2	2	2	2
	TV	1	1	2	2	2	1	2-1	1	2	2	2	2	2	2	1	2	2	2	2
	Videotape	1	1	2	2	2	1	2-1	2	1	2	2	2	2	2	2	2	2	2	2
D	Multimedia[c]	2	1	2	2	2	1	2	2											
E	Interpersonal																			
	Speech	2	2	2	1	2	2			1	1	1	1	1	1	1	2	2	2	2
	Demonstration	2	2	2	1	2	2			1	1	1	1	1	1	1	1	2	2	2
	Play/skit	2	2	2	1	2	2			2	2	2	2	2	2	1	2	1	2	2
	Role playing	2	2	2	1	2	2			2			1	2	2	1	1	2	2	2
	Simulation/games	2	2	2	1	2	2			2			1	2	2	2	2	2	2	2
	Small group discussion	2	2	2	1	2	2			2			1	2	2	2	2	2	2	2
	One-to-one counseling, interviewing, consulting	2	2	2	1	2	2			2			1	2	2	2	2	2	2	2
	Community organization	2	2		1	2	2			2			2	2	2	1	2	1	2	2
	Meetings, workshops, conferences[c]	2	2		1	2	2													

[a] Ratings: 1 = low; 2 = medium; 2 = high.

[b] Ratings assume optimal use of method or medium.

[c] Comments on effectiveness can be found in Section IV.

1 SITUATIONAL AND CONVENIENCE FACTORS

Situational and convenience factors include the considerations just cited above. Some of the points under the various categories in this list may appear to overlap. This is to encourage you to consider each factor from various points of view.

- Time. How often will the presentation take place: once, once a week, twice a day, continually, or whenever a staff person has a few minutes?

- Audience Size. Will you have a large audience? Can you break it down into smaller groups? Can you give the presentation to the entire audience? Conversely, must you present your material on a one-to-one basis?

- Audience Flow. Does the audience have time to attend an entire educational session or must teaching be done intermittently between the clients' other appointments during that visit. Do clients remain in the same building the entire time? Do they return to the facility periodically? Will you be in contact with them at another location so you can reinforce your teaching?

- Facility. Does the facility lend itself to the method you have chosen? Are there sound and light problems, distractions, young children, staff members using telephones? Is the facility crowded or is it too warm or too drafty for long sittings? Will the method interfere with other activities thus reducing staff productivity? Is there enough room to permit dividing the audience into smaller teaching groups? Is it easy to segregate new patients from old ones? Are there rooms for holding private discussions? Is the building's decor compatible with the visuals you intend using?

- Equipment. Must the equipment be moved or reinstalled, or can it be stationary? Is it portable? Can equipment be secured so that it is safe from theft? Is equipment sturdy enough to withstand continuous handling?

- Communicator. Does a staff member or volunteer have the particular skills to apply the method chosen? With what methods or modes is the staff comfortable? Will their use of teaching aids enhance or detract from the presentation? Is the staff able and willing to care for and perform light maintenance on equipment?

- Client. Do the clients show a wide difference in literacy levels, in levels of awareness, and in stages of family planning acceptance or of treatment in the clinic? Can clients be combined as one audience despite differences in learning levels? Do they find mechanical devices or sophisticated visuals distracting and unintelligible or familiar and acceptable? Are the clients primarily couples or very young women? Age, economic, and sex differences will affect selection of materials. Are women clients frequently accompanied by children who need their constant attention?

2 EFFICIENCY

Efficiency considerations involve the amount of time, staff, and money required to apply a method as well as the number of people who can be reached by the method, and the amount of time it takes to reach them.

- Cost. The costs presented in the methods and materials table are estimates for purposes of quick comparison, rather than actual dollar costs. When figuring costs, several factors should be considered: initial cost; whether it is a one-time cost (in the case of a projector) or a continuous cost (printing pamphlets); whether the materials required are already available or whether material design and production costs must be included; maintenance and repair costs; the number of people the method can reach at any one time.

- Staff Time. Will the method require much staff time? This is often the paramount consideration among administrators. And since group and individual counseling consumes considerable staff time, it may be wise to consider using audiovisual methods or mass media where they are effective. However, time alone is not the only consideration. There are others including: whether the material to be imparted can be as effectively presented in a group as on an individual basis; whether a portion of the instruction can be provided by a mechanical device; and whether a non-professional, if given sufficient training, can apply the method as effectively as the educational specialist.

- Volunteer Time. Do not be misled by believing a volunteer is "free." Volunteers require training and continuous supervision to be effective. Thus, volunteer time should be considered as a resource in your costing. You should also refrain from automatically concluding that a volunteer

should be used in place of a staff member if possible. The volunteer might contribute much more by performing another function in your program.

- Training Time. Although the staff may be willing to adopt a particular method, they may require additional training to be able to employ it. Such training time should be included in your analysis of efficiency.

- Development Time. A cost that is often overlooked is the time spent by you, the educational specialist, in developing materials, making contacts for free television time, or enlisting the aid of volunteers. Some of you are media oriented, others write well, and others are more talented in planning. Although your particular talents or preferences will influence your choice of method to some extent, hopefully they will not distract from considering how much of your time the method will take and how much it costs. In effect, if you become objective about all costs involved, you may find that you are spending more time and money than you would if you had hired a specialist or bought materials, and that you would have thereby obtained more professional work.

- Space. Additional space may be needed to accommodate a particular method. If so, this would be an additional cost. Any donated space should be considered in the same light as volunteer time -- that is, in terms of its most effective use at that point in time in your program.

- Durability. Durability concerns replacement and maintenance costs of equipment -- how well the equipment will survive continuous use by many or being moved from place to place.

3 EFFECTIVENESS

In classes on contraception, we often urge our audience to double up on methods in order to enhance the probability of success. The same holds true for communications techniques: two are frequently better than one. For example, distributing a pamphlet which relates to a discussion that is taking place; showing a portion of a movie, then stopping the projector to discuss it; and enhancing verbal presentations with slides and flip charts all reinforce learning. The following discussion outlines some of the considerations involved in judging a method's effectiveness. It is divided into two categories: characteristics of effectiveness, and effectiveness in terms of learning objectives.

CHARACTERISTICS OF EFFECTIVENESS

The effectiveness of a method can be judged according to the following characteristics.

- Interaction. As was stated, the more interaction a method permits with a person, the higher the chance that person can incorporate what he is learning into his own experience so that it will become an integral part of his thinking and behaving. Obviously, then, the more interaction a method permits the more effective it will be.

- Attention. Before any communication can take place, the speaker must have the attention of his audience. And although two methods may be equally effective in terms of communication, one may be better than the other in obtaining and holding attention by employing such things as light, color, or motion in an interesting fashion. Another attention-holding consideration is the content of the material itself. If the audience is to sustain its interest, it must identify with the material being presented.

- Pacing (retention and repetition). A method which permits returning to an item, looking again, rereading, moving at one's own pace in terms of understanding and comprehension is considered effective because such repetition aids retention -- so important when dealing with complex or critical matters. Take as examples instructions on taking pills, when to report side effects, when to resume pills after menstruation, what to do if mid-cycle bleeding takes place. Since these matters can be critical to the patient's health, the instructions should be repeated until the patient has memorized them.

LEARNING OBJECTIVES

The ratings on specific learning objectives, defined below, were adapted from an article directed toward art education.(1) The best information on the relationship between the media used and success in meeting learning objectives comes from research in the fields of formal education and industrial training. However, great caution should be exercised in applying the conclusions drawn from studies in those fields to the general field of adult education or health education. The reason is that there are different motivational and societal pressures at work in each of these settings. The student

in school and the employee whose living might be at stake are generally more highly motivated to change than the adult trying to acquire better health habits because the consequences and rewards of changing are much clearer and more immediate. Even so, it is still worthwhile to consider the findings which are shown as ratings on our table. In cases where there was little experimental evidence on a particular medium, ratings were derived on the basis of the author's observation and experience.

- Teaching Facts. As a learning objective, the imparting of facts refers to the learner's remembering definitions, events, terms, names. Although audiovisual devices -- movies, slide presentations, programmed instruction, or television -- are effective for this purpose, the evidence indicates they are no more effective in conveying information than standard presentations such as talks and printed handouts. However, films and projections do increase the audience's interest and provide variety and so are useful in sustaining attention. And as mentioned, you must have the attention of your audience before you can communicate effectively. Although there is a paucity of reliable information concerning which audiovisual device is generally best, we can say that television has no particular advantages over movies for instruction: the picture quality is poorer and the instructor cannot control the image display as directly.

  Teaching Procedures. This objective refers to teaching a person how to perform a series of acts or operations in the proper order. Such an objective might be involved in training staff members to use a projector or a patient to insert a diaphragm correctly. Although there is a lack of formal research on the subject with regard to family planning, such media as television, movies, programmed learning, and demonstrations seem the most effective when it comes to teaching procedures. The effectiveness of films has been demonstrated, for example, in teaching motor skills, particularly when learners have the opportunity to actively participate during the presentation. An excellent piece of equipment for this is the repetitive, 8 mm., single-concept, loop cassette which can be stopped or rerun at will. Some materials relating to nursing procedures are already available in cassette form but, unfortunately, little is available that is specific to family planning.

- Teaching Principles and Concepts. Our recommendation for the best media for teaching relationships among things and events as well as the principles behind various actions or activities is adapted from studies on the use of programmed instruction to teach science concepts and principles. One study compared the effectiveness of visual and verbal presentations. It found that a combination of the two was best and that learning was greater when the visual presentation preceded the verbal one.

- Developing Desirable Attitudes and Opinions. This objective concerns persuading the learner to form a preference for a particular point of view, idea, practice, or course of action. It involves influencing feelings, desires, or needs. According to the article from which we derived our learning objective ratings, there is very little evidence for favoring one medium over another in this respect. A combination of media to present all the dimensions of the particular question at hand would probably be the best solution.

Now that we have surveyed some of the considerations that are part of method selection, it might be wise for you to think over your own list of situational factors and objectives, and talk over budget considerations. The rankings may have helped you by introducing you to new ideas or reinforcing your present inclinations. In any case, by adding up the scores you should now be able to tentatively select your method or materials. The next section presents more detailed comments and considerations concerning methods, media, and materials; Section V gives the sources for obtaining them.

REFERENCES

1. Allen, William H. "Media Stimulus and Types of Learning," Audiovisual Instruction, (January, 1967).

IV. UTILIZATION OF METHODS AND MATERIALS

The use of educational methods and materials to effect change is a vast dynamic field. Not only does the field have great potential for development, [1] but it is exciting, full of promises and gadgetry. It also has such a wealth of specialties that it is easy to get lost in some corner, develop a narrow viewpoint, and become fixed on a particular method. How does the generalist stay afloat in this sea of educational technologies, theories, and methods? What are some of the dimensions of the field and some decision points, and what data are relevant for evaluating the various methods and materials available?

An overview of the field which is given in this section may help in this respect.

EDUCATIONAL TECHNOLOGY

Technological innovations hold the promise of reaching more learners at less cost per individual than traditional instruction methods. Moreover, they can offer more flexibility and a richer variety of content. Wisely used, technology can be beneficial to health education.

The traditional concept of educational technology was confined to the use of such media as radio, television, films, overhead projectors, programmed instruction, and computers as an adjunct to the standard educational methods -- teacher, blackboard, and textbook.

A more recent definition of educational technology reflects a systems approach and is defined as: a systematic way of designing, carrying out, and evaluating the total process of learning and teaching in terms of specific objectives, based on research in human learning and communication, and employing a combination of human and nonhuman media to bring about more effective instruction. To date, there have been only limited attempts to design instructional systems based upon this perspective and to implement a systems approach to instruction in teaching hospitals and universities.

EDUCATIONAL TECHNOLOGY IN FAMILY PLANNING

The two most sophisticated uses of educational technology in family planning thus far can be found at New York City's Harlem Hospital and Kapiolani Hospital in Hawaii. Harlem uses programmed instruction to teach contraception via film. When the patient pushes an electronic response key, the screen responds to correct and incorrect answers. According to the staff, this

system is quite effective in instructing patients. Kapiolani presents eight hours of TV programming a day for three days on a variety of family planning subjects. Patients watch these closed circuit TV programs on standard monitors in their rooms. Individual instruction and follow-up are also provided. The program is in the process of being evaluated.

EDUCATIONAL TECHNOLOGY IN RELATED FIELDS

The largest use of educational technology is in the school. Although it was predicted that such technology would revolutionize teaching, this has yet to occur.[1] The second largest use is in the area of business and industrial training. Since the benefits in terms of increased productivity and skill are fairly direct and immediate, the investment in such training is sizeable. Both of these fields are well organized in the sense that they have associations, magazines, directories, trade shows, information on new developments, and professional training programs.

Institutions which are just beginning to utilize educational technology heavily are the professional health and medical training schools and hospitals. In fact, the government has invested a considerable amount in encouraging the use of technology in medical education. Unlike the fields of public and industrial education, medical education lacks centralized coordination.

No comparable investment in educational technology has been made in the community health field even though there is evidence to show that considerable money could be saved as a result of effective preventive health education and patient education programs. Those savings, however, would frequently accrue to the "unorganized" consumer. Thus, there is lack of incentive for the "investor." Unfortunately, the state of the art in community education is such that it is necessary to pick and borrow technologies from related fields and to depend upon the few professionally developed materials and research studies available.

MASS COMMUNICATION

Mass communication and advertising is another related field from which family planning has borrowed methodology. However, the advertiser aims toward evoking one clear-cut, single action from his audience, a goal which in most cases is not present in family planning. Motivation to adopt family planning is more diffuse, and, thus, the objectives and action desired are more complex.

A recent experiment dealing with family planning recruitment techniques concluded that, of the three methods tested, mass media was the most expensive. Word-of-mouth outreach recruitment by satisfied patients was the best and least expensive method, and outreach programs fell somewhere in between.[2]

Green, et al.,[3] found that in Pakistan patients recruited via mass media advertising attended family planning sessions over a longer span of time. They concluded, however, that the advertising attracted couples who were already willing to accept family planning. Since family planning programs in the U.S. seldom have had budgets to buy media time, they must confine their use of the media primarily to public service programs and other free programming time.

FREE PROMOTIONAL SPACE AND MEDIA TIME

The amount and kind of free promotional space and media time you acquire will depend upon the skill with which you can tailor your spots, feature stories, and comments to the station's or publication's format. Sources for such free promotion include news programs, public service spots on TV and radio, talk shows, and feature columns. Suburban and weekly newspapers often provide more space for features than metropolitan dailies. Other sources of free promotion include organization and agency newsletters, house organs, union papers, ethnic papers, advertising sheets, and throw-aways.[4,5,6]

DO-IT-YOURSELF PRODUCTION VS. PROFESSIONAL PRODUCTION

Judging from the state of the art, production of family planning materials in this country is a farily large cottage industry, comprised of uncoordinated agencies. A number have embarked on producing their own material for the media, including expensive movies, without the requisite experience or without having thoroughly surveyed the field. Others, the purists, refuse to employ any teaching aid that is not professionally produced even though it might be helpful to use simple, unpretentious materials. It is true that some specialized areas including family planning do not generate a large enough market to interest professionals in the field of materials development so that the agency may be forced to develop some of its own materials. Clearly, if the budget is severly limited, there is little choice but to engage in do-it-yourself production; and if it is not, the agency can and will hire professionals to design teaching aids. It's when the budget constraints are mid-range that the decision becomes difficult.

There are two other instances in which an agency must produce its own materials: when the information to be imparted is so specific to a given community or group that a generally produced piece would not be appropriate; and when an amateurish quality is more effective, as it is in some instances. For example, the amateur's touch can convey sincerity, honest concern, and trustworthiness. This is why neighborhood groups sometimes instinctively turn to mimeographing, passing up glossy four-color handouts as establishment products. As another example, certain less sophisticated groups (children, rural residents, people who are non-verbal in their orientation) respond more readily to simple, home spun teaching aids. These aids might include puppets, flannel boards, sketches, and chalktalks.

On the other hand, there are instances where it may not be essential, but preferable to produce your own aids such as when the process of developing them is itself a part of the educational plan. In fact, Kodak[7] has excellent materials on movie making as an educational tool in which the process of planning a film becomes the mechanism by which those producing it define and deal with their own attitudes, their problems, and the solutions. One of the best examples of such learning involved a group of inner-city teenagers and Dr. Betty Coggswell who produced an "Adolescent Photographic Essay." A fairly inexpensive technique, the presentation consisted of photos with large black script on white cardboard bound in flip-chart form. The photos have a poignant, sensitive quality, and the narrative reveals these teenagers' feelings concerning their relationships with the opposite sex. It resulted in a learning experience for them and for their mentor, and in something that could be shared with others as a genuine statement.

A middle road between non-professional and professional materials production is to have the materials produced semi-professionally. Students in the field of art or communications or non-professionals who have experience in the field may be available and willing to help.

If you have eliminated the option of having your materials professionally produced, then there are several things to keep in mind:

- Collect materials produced by others before deciding to begin production. Ideas are seldom new, and you can generally learn faster and save time by simply adapting and improving upon the work of others.

- Be sure you cost out the entire project before you make the final decision to go ahead.
- Obtain all the expertise you can beg, borrow, or hire.
- If you must be the expert, then read about the particular process you want to use to make the material as professional as possible.
- Pretest, modify, and then retest the materials.

PRETESTING

Pretesting is a method of applying objective measures during the develcpment of a program or materials to identify any problems as early as possible. Obviously improvements can be made more quickly and will be less costly if implemented during the early stages of development. When pretesting materials for family planning education programs, these are the questions you will probably want answered:

- How many persons will be reached?
- Of the persons reached, how many will be influenced psychologically?
- How many will find that the program offers a means of satisfying a desire or achieving a goal?
- How many will find that the behavior asked of them is in accord with the way they think people usually behave?
- How many will understand the words, concepts, and illustrations used?
- How many will really comprehend the point of the message?
- How many will acquire and retain the information and attitudes essential to adopt the behavior required?

There are pretesting techniques, of course, and methods of creating a pretest situation which is fairly close to the real one. Many of these techniques are discussed in the "Application of Pretesting in Health Education."(8)

KEEPING ABREAST OF NEW DEVELOPMENTS IN EDUCATIONAL MATERIALS

As mentioned, health education as a field lacks coordination, standardization, and cooperation. Resources are fragmented, time and money is spent on reinventing or rediscovering and on searching for, evaluating, and producing materials. The field of family planning education is no exception. It, too, has no centralized source of information on materials. Thus, you must either spend an inordinate amount of time collecting, sorting, retrieving, and evaluating, or depend upon agencies such as areawide family planning coordinating councils, Planned Parenthood, regional training centers, and large family planning agencies. However, new sources keep appearing all the time. Ways of keeping up include reading periodicals such as Family Planning Perspectives, Family Planning Digest, and professional journals; being placed on materials and catalog mailing lists; attending conventions and workshops; and taking classes.

In terms of developments in educational hardware, the best methods of keeping up to date are to attend trade shows and conventions; join AECT or ASTD; read available journals; and peruse the annual AV Directory. The Directory is indispensable for pricing and for selecting hardware because it provides comparative information, pictures of every piece of equipment, and the manufacturer's single unit list price. Each listing includes the company, model, price, and such specifications as views, lamp magnification, viewing screen size, overall dimensions and weight, current required, accessories available, and amplification.

The remainder of this chapter is devoted to a discussion of how to use methods, materials, and media in family planning. Included are visuals, audio methods, audiovisuals, multimedia packages, and interpersonal approaches.

A VISUALS

Visuals are images of people, places, events, and things. They may be:

- Expository -- a general description
- Interpretive -- emphasis on conveying feelings, emotions, symbolism
- Technical -- emphasis on specialized, detailed information.

Materials in the visual field -- sometimes called software -- contain the messages or learning symbols that support instruction. Non-projected visuals include charts, posters, and flip charts. Projected visuals, sometimes called media, include films, slides, and videotapes. The projected visuals require the use of hardware or mechanical devices.

The design characteristics of a good visual are legibility, simplicity, accuracy, realism, colorfulness, durability, and manageability.

If you are using a visual as part of a presentation (for example, flip charts, slides), you should begin by considering a suitable environment (for example, a room of sufficient size with window shades) and assembling the necessary equipment (slide projector, chart board). During your presentation, you should display each visual at the appropriate time, explain the message, use a pointer if necessary, and use assistants if available and if required. Since you will be able to give verbal explanations, your visuals can be fairly simple and should not contain detailed information.(9)

Visuals which stand alone such as billboards, posters, and pictures are not supplemented by verbal explanations and so may require captions or written comments. The essence of such visuals is: brevity, simplicity, idea, color, and layout.

Visuals used in a sequence, for example, a slide presentation, a flip chart presentation, or even a series of posters, should be conceived as a total presentation, not as a series of isolated visuals. You may provide unity though the use of color -- the same color or a group of colors used on each visual; design -- the same style of drawing or lettering, the same degree of complexity; or language -- approximately the same amount of text and the same literary style. Color may be used to emphasize one picture; it may also be used to identify similar aspects of many visuals (color coding).

In planning a 35 mm. slide series or an extensive chart presentation, the following steps should be taken:(10)

- Planning. Establish the objective of the communication, identify the audience behavior that should result, and ensure that all verbal and visual content supports the objective.

- Analyzing the audience. Learn who they are, what they believe, and how much they know about family planning and can understand at one time.

- Collecting and organizing. Present each idea or concept and a corresponding visual, if possible, on storyboards -- cards of a size that are easy to handle.

- Grouping and editing. Rearrange the storyboards to change relationships between ideas or to alter the chronology of their presentation until you are satisfied that your thoughts are expressed in the best way possible.

Throughout your preparation of a visual presentation, you should ask yourself the following questions: (11)

- Are the visuals effective in helping me reach my objectives with this audience?

- Should any part of the script be rewritten to increase its effectiveness?

- Is the information in each visual clear and accurate? Suitable for the occasion? Visible at a distance?

- Do the visuals relate to each other in a consistent way -- systematic development, terminology, color coding, lettering?

- Do I have time to make any necessary changes in the visuals?

Extensive information on designing effective technical slides for instructional purposes and on using charts and graphs is contained in several excellent Kodak pamphlets. (12)

Using visuals to intentionally communicate messages or interpreting intentional visual communications has given rise to a whole new educational area labeled visual literacy. It involves a wide range of academic disciplines and sciences and involves concepts such as cognition, art, semantics, the meaning of meaning, and visual-verbal thinking. Conferences have been held on visual literacy and appropriate materials assembled. You may find some of these materials helpful. (13,14)

WRITING

Skill in writing comes from practice, not from reading about writing. Consequently, the most helpful aid is someone who will pay close attention to your writing and help you improve it. If this is not possible, you might refer to a work by Flesch, "How to Write, Speak, and Think More Effectively."(15)

Flesch indicates that readability depends on: your reader's attention span, his familiarity with the words you use, references to concrete things, his language habits and patterns, and the overall structure of what you say. Flesch also includes two interesting measuring steps for assessing your writing: a reading ease score and a human interest score.

Writing, in the context of family planning education, often involves the writing of pamphlets. In designing a pamphlet, you should consider the following:

- Audience. Consider age, sex, race, education, cultural background, occupations, knowledge of subject, attitudes, interests, and particular needs.

- Objective. If your objective is to arouse interest or develop attitudes, make the pamphlet attractive and emotionally appealing. If you want to change behaviors, present specific steps to action, what to do, why, and how.

- Use. If the reader is expected to read the pamphlet and then throw it away, use a flyer or simple folder. If he is to keep it for reference, it may be longer, more durable, and more expensive.

- Design. Is the pamphlet attractive and designed for easy reading? Does the cover stimulate and attract? Are the pages well designed? Is the type size familiar and easy to read? Are devices for emphasis used sparingly? Are the illustrations appealing?

- Text. Is the material well written? Do titles capture attention and stimulate interest? Is the subject matter well organized? Is all essential information included? Is there too much information? Is the language easy to understand? Is the approach positive? Will the reader remember essential points?

PROGRAMMED INSTRUCTION

With programmed instruction, the educational subject matter is divided into small steps and arranged in a careful sequence. The student reads or views one information segment at a time, digests the information, and then proceeds to the next segment -- at his own pace, not the group's. Opportunities are regularly provided for the student to test himself on his comprehension of the material.

Some programmed materials permit the student to branch off to different tracks. For example, if a student has difficulty understanding certain information, he may branch off to supplementary material in that area. Students with no difficulties would progress to new material. Computer assisted instruction, in which responses are recorded by a computer, can offer many branching possibilities. Computers can also measure and score the pupils' progress.

Programmed instruction is listed in Table 1 under printed materials because most of such instruction is presented in manuals. However, it is possible to program instruction for television or any other medium. Two types of individualized instruction which have been tried in family planning are: a programmed manual on contraception for second-year medical students and the responsive programmed film on contraception used in the postpartum ward of Harlem Hospital.

The usefulness of programmed instruction to you lies in its method of specifying learning objectives and in breaking instruction into small basic steps. This approach can help you plan sequential presentations in training or in designing a slide series.

B AUDIO METHODS

According to one survey, the time spent in personal communications is distributed as follows: reading, 4 percent; writing, 11 percent; speaking, 22 percent; and listening, 63 percent. Since the transmission of information is so dependent on listening, some attention should be given to improving listening skills, especially those of the staff. (16)

Some of the elements of effective listening are: withholding evaluation until the speaker finishes a thought; not attributing thoughts to the speaker which are not his; paying attention, maintaining open-minded attitudes; allowing the semantic interpretation to be the speaker's, not the listener's; and doing less talking and more listening.[17]

In attempting to reach prospective clients, a variety of audio techniques may be used:

- An audio message to complement a visual such as a motion picture. In using this technique, you should remember that the narrative should not describe the action. Words should supplement, not repeat. They should point out significant details and tell what to look for next rather than describe what people can easily see for themselves. Pictures do not have to have sound every second. Too much sound can even interfere with comprehension.

- Radio messages for recruitment and information purposes. Radio spots on shows of popular disc jockeys can be particularly effective in reaching young adults.

- Audio cassettes. Audio cassettes, for example, are available for postpartum instruction and have been used in hospitals with success.

- Telephone calls for follow-up of patients, reminders for clinic appointments, and patients' discussion of symptoms or problems. The telephone can also be used for opinion surveying. It is less expensive than house-to-house surveying. The people telephoned can be judged on their representativeness by asking questions on education, income, location, etc. Having a telephone, however, is a selective factor and eliminates the poor, those in group living quarters, and the mobile.

C AUDIOVISUALS

Audiovisual aids can be used effectively for the following purposes:

- Repetition of a message on a regular basis

- Introduction of ideas

- Reinforcement of points already made
- Reinforcement of ideas at another time or another location
- Reduction of staff time
- Entertainment or diversion in a waiting period.

Most available commercial material in family planning is on 16 mm. film or film strips with sound. The best films are those that use film for what it does best -- create dramatic impact, compress time or speed up or slow down, compress distance, capture events or sequences of events, use motion to show the relationships of one idea to another, magnify detail, build continuity of thought. The worst films are those that only show people talking. (It's better to have real people talk than to show it on film.) Most good films, moreover, cover a single concept rather than a variety of information.

The content of most of the films in the field is well known to you -- why you should plan a family or how you go about it. There are also professional and technical films, training films on human relationships, and health related films such as those on baby care, nutrition, venereal disease, and cancer detection. Films on ecology and its relationship to population growth were popular a year or so ago; current productions seem to emphasize sexuality and sex education for teenagers.

Unless you have a trustworthy source who can recommend a film to meet your specific objectives, you will have to spend a great deal of time in prescreening and selecting films. A list of available films can be compiled by contacting the suppliers listed in Section V.

In obtaining the films you select, carefully weigh buying against renting. Buying implies problems of film repair which takes time and expertise, as well as obsolescence and replacement costs. Renting, on the other hand, implies delays, advance scheduling, packaging, mailing, and insurance.

To get the most from a film presentation:

- Preview the film in its entirety
- Introduce the film by alerting the audience to its key points
- Learn how to handle films or have an experienced operator set the projector up in advance so it works when the lights go down. Film can be destroyed through poor handling.
- Discuss the film. Allow time for the audience to react to key points mentioned.
- Consider using only portions of the film as a means of stimulating discussion. Select isolated key ideas. Set the film to that section in advance. Show, discuss, reverse, show again.

A film evaluation file can be a useful reference and time saver. You should keep information on the films you rejected as well as on the films you used. Otherwise, you may find yourself viewing a recommended item, only to find that you had already rejected it. Figure 4 is a sample film evaluation sheet which you might want to use or adapt to your particular program.

Additional information on projected visuals is presented in Table 2.

VIDEOTAPES

Totally professional educational and training films can be made with video equipment if extremely expensive studio-type hardware and specially trained personnel are used. But before you get too enthusiastic, consider the following factors. The actual cost of producing a videotape is usually higher than initially anticipated by the program planner. Video production also requires space, people, equipment, and time. Usage tends to be low, purchased equipment is soon outdated, and maintenance costs may be considerable. (Low cost systems produce a low quality film, and thus their use is limited to internal training purposes.) Moreover, not all videotapes can be played on all videotape machines, and this technical incompatibility may result in the wasting of valuable resources.

FIGURE 4
A SAMPLE FILM EVALUATION SHEET

FILM EVALUATION

NAME OF FILM _____ Overall Rating 3 2 1 -1 -2 -3

Producer _____ Format Film 16 mm. ___ 8 mm. ___

Source _____ Filmstrip ____ Video Tape ____

Cost $___ Rental ___ Free ____ Slides ____ Other _____

Production Date _____ Preview Date _____ Sound yes ___ no ___

Brief Description B&W ____ Color ____ Length ____

AUDIENCE

Preteen ___ Teen ___ Y. Adult ___ 25/45____ 45 ____ Ethnic _____

Patients ___ Couples ___ Parents ___ Men___ Educators ___ Health Professionals ____

Socioeconomic and Educational Level _____

Inner City ____ Suburban ____ Rural ____ Other _____

FILM USE Training ___ (Profess ___ Parapro ____) Patient Ed ___ Gen Community ___

Community Support ___ Teen (Class ___ Informal Discussion _____)

CONTENT

Circle the number which corresponds with your opinion on the work in question.

Scientific accuracy (if relevant)	3	2	1	-1	-2	-3
Effectiveness as a teaching aid	3	2	1	-1	-2	-3
Clarity of message	3	2	1	-1	-2	-3
Creativity of presentation	3	2	1	-1	-2	-3
Technical quality of production	3	2	1	-1	-2	-3
Audience appeal and attention	3	2	1	-1	-2	-3
Degree to which this work could produce more realistic attitudes	3	2	1	-1	-2	-3

Use this space or the reverse side for any additional remarks.

TABLE 2

MATERIALS RELATED TO FAMILY PLANNING

Projector	Commercial Availability	Local Production	Cost: Software	Cost: Equipment	Hardware	Use	Individual	Small Group (2-15)	Large Group (50+)	Classroom (5-20)
Slide	Limited	Requires 35 mm. camera. Color or b&w. Inexpensive, duplicates inexpensive. Flexible for edit and change. Quickly made, local developing. Effective. Captions, silent or automatic sync with tape. Holds image on screen.	$5 for 30 slides	$50 to $1000	Manual, remote control, automatic & continuous. Silent, tape or sync. Store in trays, cubes or carousels. Hand-portable.	Self training, small group, classroom, large group. Can run automatically in clinic, ward, hall, exhibit. Operator requires instruction.	Fair	Good	Excellent	Excellent
Filmstrip	Yes	See above. Not as flexible as slides for editing.			Manual, automatic. Cassettes.					
	Buy	Compact & convenient to carry. Uses photos, art frames. Requires 1/2 frames when using slides. Local developing. Mass duplication cheaper than slides.	$2 per frame	$30 to $400	Continuous, no rewind. Cassettes with magnetic tape sound; others silent, sync with tape or disc. Stored in small cylinders, hand-portable. Some projectors adapt to slides.	See above, plus individual use. Cassettes do not require operator.	Good	Good	Excellent	Excellent
Movie 16 mm.	Yes Buy or rent.	Expensive to produce. Requires expertise. Usually color. Usually sound. Dependable, effective. Not flexible.	$1000+ per minute	$600 - $2000	Standard with sound. Hand carry with difficulty. Operator required.	Training, small group, large group, classroom. Rearview can be set automatically for exhibit.	Poor	Good	Excellent	Excellent
Movie Super 8 mm.	Limited to professional health training in 4-min. single concept loops.	Requires editing and splicing equipment. Color. Silent -- can be used with tape recorder. Not flexible.	$5 - $10/ 3 minutes	$100 - $600	Commercial continuous loops easy to handle, have magnetic tape sound. Very portable, storage simple. Have not been utilized much.	Local settings & situations, training, small group, classroom.	Good	Excellent	Fair	Poor
Overhead	Some school materials on sex education, K-12.	Transparencies. Cheap, speedy. Used for charts & graphs, sketches, overlays, sequentials. Presenter can write and draw during talks. Control-- speaker faces group, has eye contact. Flexible.	Under $2/copy	$150 - $500	Effective in lighted room. Easy to handle. Materials store flat in file. Small model carries like a typewriter. Large model can be moved on cart.	Training, classroom, technical, talk.	Poor	Good	Excellent	Excellent
Opaque		Reflects what is inserted. Materials already available. Can use books, pictures, models. Accurate, speedy, no processing required.	Use existing material	$300 - $700	Heavy, move on cart.	Suitable for training or classroom. Not suitable for most agencies.	Poor	Good	Excellent	Excellent

Because of the costs involved in videotaping, family planners in programs connected with hospitals and large teaching facilities will be the ones most likely to need information in this area. The following brief discussion is provided simply to give enough information to enable you to ask the right questions or just to understand what the experts are talking about.

The variety and complexity of the video equipment available makes it difficult to select a specific type of equipment. Moreover, the possibility of technical incompatibility must be thoroughly checked.

You may be interested in video cassettes and cartridges. They are easy to operate, travel well, handle well, and are reusable. They do not, however, offer any special advantages in production or in duplication over open reel. With regard to "canned" television, magnetic tapes are the only methods currently on the market.

The size of magnetic tape used ranges from quarter-inch (low image quality, used in homes and schools) to two-inch (used in commercial television). Three-quarter inch tape is considered adequate for most use, although the one-inch tape produces a semi-professional quality. Magnetic tape for CCTV systems has not been compatible in the past. In order to use tapes from one system in another system, you may have to have the tapes duplicated.

It is possible to make your own copies of existing movies on magnetic tape, although the quality of the resulting film is often questionable. For a relatively low cost ($25 to $50) you can retape existing movies if you have permission. Some agencies will supply their films for this purpose. The only cost to you is the expense of converting the films to videotapes. Cincinnati General Hospital, for example, borrowed films and prepared five 90-minute cassettes, each containing about eight health films. They are played sequentially through the day and include an additional three-minute film explaining why patients must occasionally wait for their appointments.

The chart shown in Figure 5 may be helpful to you in selecting video equipment.

FIGURE 5 VIDEO EQUIPMENT DATA

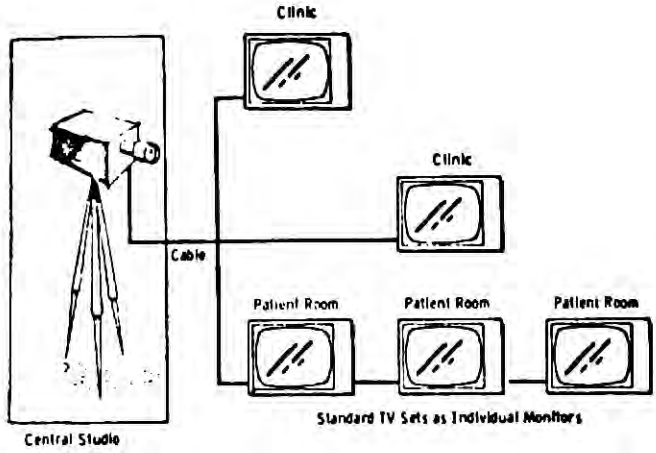
Tape Size	Type	Brands	Compatible	Features
1/2 inch	Open reel	All brands	No	Early machines are non standard
	Cassette & cartridge	Panasonic Shibaden Concord	Yes	Standard last 3 yrs
		Sears		For home entertainment
3/4	U-matic cassette	Sony Panasonic Wollensak Concord JVC	Yes	Check features & additions of new equipment Color Many purchased for hospital and training use
	Selectavision MagTape cartridge	RCA Bell & Howell	Yes	For home entertainment

CLOSED CIRCUIT TELEVISION

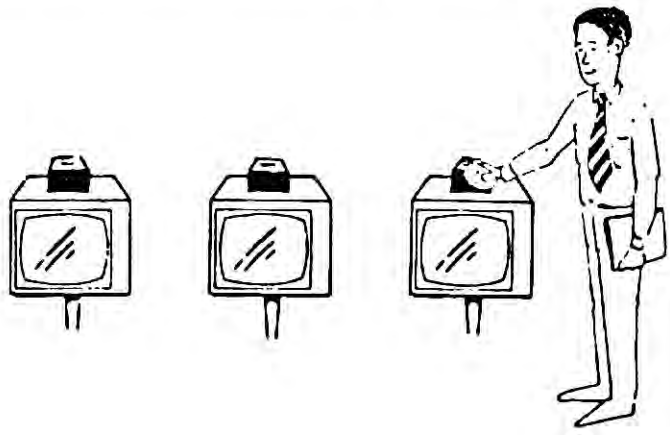
Closed circuit television is a centralized system which broadcasts simultaneously to several remote locations. In the case of family planning education programs, the locations would be clinics, patient rooms, or waiting rooms. The advantages of such a system are:

- One trained individual can handle all hardware and software.
- The transmission of programs is not dependent on the whim of the receptionist.
- Films can be used directly without being transferred to videotapes.
- The same material can be broadcast simultaneously to numerous locations.
- CCTV is relatively flexible. A simple system could be installed initially and later upgraded to include monitors in additional patient rooms, random access to a computer via touchtone phones, monitors in other agencies, monitors in other clinics to be used for consultation and lectures, etc.

The disadvantage is that a large initial investment for cabling, a studio, and technical expertise is required.



An alternative to the centralized system is individual monitors or standard television sets which use videocassette cartridges. The cartridges, which are inserted into the unit by hand, can be tailored to the needs of the individual. This system can be tested using only a few units, and so the initial investment is less than with centralized CCTV. Each unit of hardware costs the same amount, and so there are no economies of scale.



The ideal television system would be one that would combine the benefits of both systems described above by offering general information at many locations as well as specialized instructions to individual patients.

D MULTIMEDIA PACKAGES

A multimedia approach involves combining various types of instructional materials for maximum learning input. Combinations are limited only by the availability of resources, facilities, and services. Examples would be using a manual or pictures along with an audio cassette; or an audiotape along with a film strip, a written quiz, and a take-home pamphlet. There is equipment on the market which combines automated and manually controlled operations in presenting sound or silent filmstrips, motion pictures, slides with taped narrations, and quizzes. The machine can be stopped and the film replayed at the desire of the individual.

Some programs may already be using this approach, although they probably have not packaged and advertised the combination as multimedia!

E INTERPERSONAL METHODS

Interpersonal methods, which necessitate the intensive involvement of persons, can be used with or without combinations of methods discussed previously. These methods introduce a different dimension into communication involving humans because of the simultaneous multiple messages sent on several emotional and physical levels.

Skill in using yourself as a communicator can be gained through a number of class and workshop methods. This learning must be on the applied, practical level; it cannot be developed through the straight academic approach. Some of the possible ways of developing skills are mentioned in the following pages. Since opportunities for speech, discussion, and drama abound, these topics are not dealt with here.

The interpersonal methods discussed below lend themselves particularly to training and to consumer involvement. Group discussion and role playing, moreover, are the most useful methods for helping persons integrate new information and change attitudes. Therefore, they lend themselves well to patient education and to working with young people and parents.

DISCUSSION AND SMALL GROUP MEETINGS

One method of carrying on purposeful talks with co-workers or clients is group discussion, which may be defined as an exchange of ideas between two or more people -- the raising of questions and the posing of answers. It may be described as group thinking.

Good group discussions will:

- Develop a clear understanding of ideas and stimulate the search for information
- Allow an individual to benefit from opinions expressed by all group members
- Develop a questioning, searching attitude of not accepting ideas without thoroughly understanding them
- Result in the realization that there are many sides to any given question
- Develop a sense of tolerance in the individuals, thus paving the way for translating group thinking into intelligent group action
- Develop self-respect and a sense of equality among participants.

The ideal size for a small group is from four to seven people. Smaller groups will be ineffectual if power problems develop among the members.

In a discussion group, the leader's role is to act as an enabler or facilitator -- to open the discussion, establish a friendly climate, stimulate interest in the topic, and start the conversation by asking questions that cannot be answered by "yes" or "no." The leader should not act as an authority or dominate the discussion, but be a good listener and try to draw out the members of the group. The leader, however, should be able to sense when the group is ready to move to a new topic and be able to provide summary and transitions. It should be noted that the same person does not have to be the leader for every discussion. Indeed, the more diffuse the leadership, the stronger and healthier the group. The role of the resource person in the group is to supply technical information and to provide answers to questions that have been raised previously.

A conference, or small group meeting, is an in-house meeting used for administrative or medical reasons. Its function is to allow the group to analyze a specific problem, recommend solutions, and establish follow-up plans. Conferences make it possible to use staff time efficiently since information can be communicated to more than one person at a time. More importantly, research has shown that decisions made during small group discussions are more lasting because peer group support is generated. This is an important consideration in family planning education.

In attempting to develop skills in interacting and communicating with people, one basic problem is that study about does not necessarily confer skill in these areas.[18,19,20] The best way to gain discussion skills is through relevant workshops and classes available through colleges and training institutions. The National Training Laboratories was one of the pioneers in this field and holds workshops in several locations. In addition, having a skilled person supervise your progress is helpful. Skill improvement is one of the best uses for videotape -- to film, play back, analyze, and replay interactions.

GAMES AND SIMULATIONS

Games used as learning and training tools include simulations, board games, role playing, computerized responses, or various combinations of these. And they have two components: a rational, analytic one and one which is emotional, creative, and dramatic. Games provide training in complex processes such as intuition-building, problem solving, social behavior, allocation of resources to maximize objectives, and in dealing with parallel processes, the dynamics of interaction, and uncertainty. They are highly motivating and communicate concepts and facts on many subjects efficiently because they can be fun as well as engrossing.[21]

Role playing can be utilized as a learning method alone or as an element of a game. Since it requires interpersonal skills and training, it is included for further comment.

ROLE PLAYING

Role playing is a way of presenting problems in human relations in the context of a training group or social laboratory. As such, it is an opportunity for the group members to experiment with their own behavior, to make mistakes, and to try new approaches without having to bear the consequences

or recriminations that could result in a real life situation. Because the environment is artificial and the others present are co-learners and not judges, the learner is freer to try new modes of behavior.

As a training technique, role playing has proven extremely effective in developing attitude changes. The reason is that through improvisation the participants begin to see themselves as others see them and to appreciate other points of view.

Improvisation is a technique whereby the members of the group are given the general outline of a situation and then assigned roles to act out in it as they would in real life. There are no lines to memorize and no specified plot. Rather, the situation is permitted to unfold as the players react spontaneously to one another, unaware in the beginning of the other players' roles. The cast is confined to three or four players; the rest of the group observe. Both profit: the players by experiencing the situation, the observers by noting the players' behavioral mistakes. During the post-mortem the instructor may bring up certain important points regarding what occurred during the improvisation or may suggest replaying the scene after the discussion to demonstrate the effects of a different behavioral approach to the problem. In any case, the instructor must know how to guide the discussion wisely, when to halt an improvisation, and when to take a dominant or passive role in the group.

LARGE GROUPS, CONFERENCES, WORKSHOPS, CONVENTIONS

There are several educational methods geared to large groups of over 50 people. They range from lectures to audience participation techniques.

The various types of group meetings are discussed below according to their educational aims. (22)

- Clinic. The clinic is held to study specific content or phenomena. And since the participants in a clinic are considered learners with little experience, sessions are strictly instructional and highly diagnostic in terms of identifying and remedying gaps in the participants' knowledge or skills.

- Conference. The primary objective of a conference is to permit participants to share information concerning various problems or procedures. Thus, although lectures or speeches are represented by specialists, participants are also expected to contribute ideas and information.

- Convention. A formal annual meeting, a convention is run by protocol and specific rules of order. Although educational activities may take place, the major purpose is to conduct organizational affairs.

- Institute. As in the case of a clinic, the institute's primary aim is to educate the participants. Thus, sessions are also highly instructional and conducted by outside experts.

- Laboratory. In a laboratory, participants are expected to learn from one another under the guidance of an instructor. The instructor's role then is to create the environment which is conducive to learning.

- Seminar. The seminar gives people who are fairly experienced in their field the opportunity to discuss certain topics with one or more people. There is considerable exchange of information and experiences, but rarely any problem solving or planning.

- Symposium. The symposium provides the platform for presenting several points of view. It permits the in-depth exploration of a limited number of subjects, and it is relatively structured in format.

- Work Conference. Generally an organizational function, the work conference aims to examine and solve various organizational problems. It involves a detailed study of the organization's processes and systems under the guidance of supervisors of functional or staff areas.

- Workshop. The workshop is conducted to help participants master a certain skill or technique. Participants learn from resource people who assume the role of instructor.

If you consider the large meeting as the background for instruction, you must also calculate the costs. This is done in the following manner. Consider first the cost of the time the presenter will devote: his hourly salary multiplied by the number of hours for production, the number of hours for planning, and the number of hours away from home. Then add travel costs

and per diem, plus the sponsor's costs for facilities, equipment, program staff, and publicity. Next, multiply the expected number of people in the audience by the hourly dollar value of their productivity and the number of hours they will be attending the presentation; add their travel costs to the meeting. The sum of these figures is your total dollar investment. That figure will probably be high, which is the reason such a project should be planned carefully and methods and materials selected wisely.

COMMUNITY ORGANIZATION FOR ACTION

There are very definite steps in creating an effective social action program for educating the community in family planning. The first, and most obvious, is to gather information on the community to determine the type of people you will be dealing with, the problems the community faces, and what must be done to achieve acceptance of family planning on a community-wide basis.

The next step is to contact community leaders and organizations to learn whether some aspect of family planning is critical to their community. Their agreement and support is vital to the eventual widespread adoption and acceptance of your program. If the community leadership agrees that the action is essential, then the next step is to ascertain whether the public also agrees. It is at this stage that information efforts take precedence to make as many people as possible aware of the problems and accept the solutions. These efforts may involve basic educational programs, utilizing community crises to drive home a point, or forming program development committees comprised of community residents. The last points up that active participation in the program by the ordinary citizens is crucial to its ultimate acceptance. In fact, you must seek citizen commitment to action at every stage: commitment to attend meetings, to act at the proper time, to pledge support, and to take part.

In addition, if the committees are to function as successful action groups, they must be aware of and effectively utilize the interactions among committee members and between the committees and the community. Figure 6 illustrates these interactions and how they should mesh in the early stages of forming and meeting program objectives.

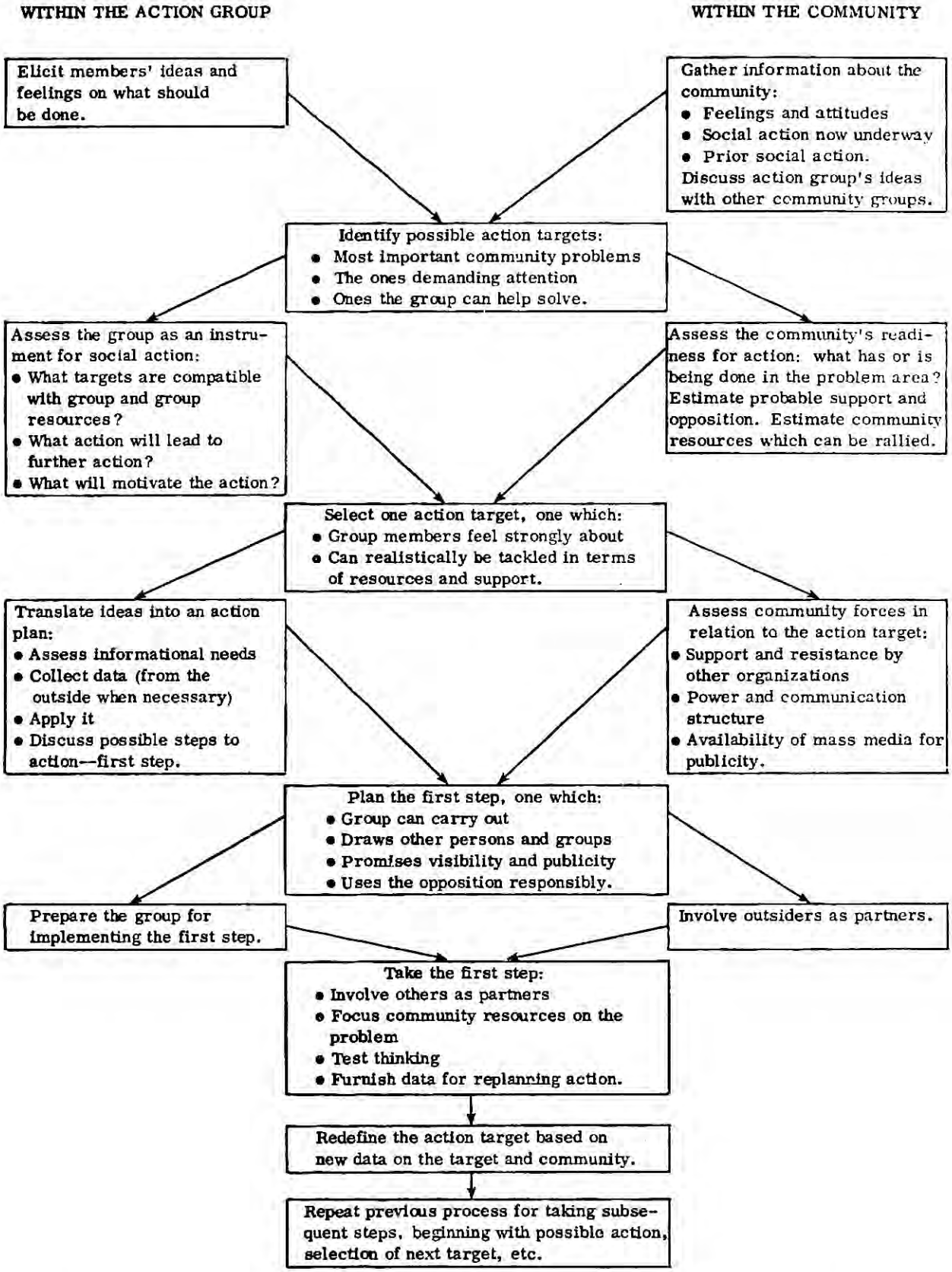


Figure 6. Group and Community Interaction in the Planning and Implementation Processes

There are several approaches to community organization: [23,24,25]

- The community development model in which consensus is the vehicle for helping the community determine and solve its own problems
- Social action in which confrontation and negotiation are used to organize and mobilize people against the establishment
- Social planning in which problems are approached as the organization of technical resources to solve a specific problem
- The educational approach which combines all of these methods both for specific problem solving and developing the capacity of the community to change.

Family planning programs which take the educational approach must develop a consensus as well as organize and coordinate technical resources to provide services and to identify and solve problems. It is hoped that in the process of achieving family planning goals, community members will acquire problem-solving skills which they will carry over into other health areas.

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This paper offers a pragmatic framework for evaluating the health education activities of a family planning program. This framework comprises the components of the program. These are related to five types of measurements. The author indicates how such a matrix may be used to evaluate health education activities.

TOWARD A FRAMEWORK FOR EVALUATING HEALTH EDUCATION ACTIVITIES OF A FAMILY PLANNING PROGRAM

Susan F. Klein, M.P.H.

Introduction

IN program planning, health education has habitually borrowed knowledge and techniques from other disciplines and combined them to form a new aggregation of information. Education, communications, sociology, anthropology, psychology, medicine, and epidemiology have been major contributors to our profession. In program evaluation, however, health education has not yet taken fullest advantage of the technology which lies in other fields. Much to its disadvantage, health education has rarely made use of the experiences of leaders in the field of evaluation.

Together, public and business administrators, behavioral scientists, and administrators of branches of the United States government have been developing a new approach to program planning and evaluation which has become known as Systems Science. Combined with principles from biological and physical sciences, General Systems Theory (GST) has emerged.[1,2] In recent years, much has been heard about such aspects of Systems Science as systems analysis, cybernetics, human engineering, and operations research.

This paper is not designed to give an exhaustive description of the systems approach nor even a comprehensive one. Its intent is merely to introduce some systems thinking into health education evaluation. The systems approach is generally used to build a new system but can also be used successfully to analyze an existing one so that it may be modified or changed where necessary. In this case, the systems approach will be used in developing a framework for evaluating the health education activities of a large-scale family planning program. This proposed framework is based on the components of the system and quantifiable measures of the activities of these components.

Family planning program for purposes of this paper means a centrally administered organization under the auspices of which a series of clinics operates, offering contraceptive services to the public. This includes such programs as the Maternal and Infant Care (MIC) Project in New

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York City, Planned Parenthood of America, and the many National Family Planning programs throughout the world.

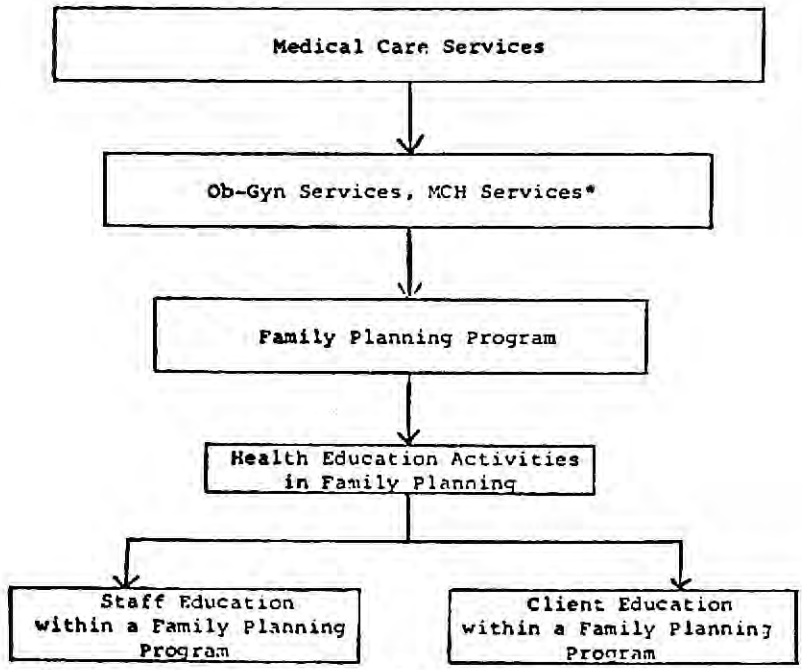
Health education activities, in this paper, are not limited to those activities carried out by professional health educators or even those working in health education on a full-time basis. Here, health education activities involve education given to the client by all members of the staff including physicians, nurses, clinics assistants, clerks, and the like.

The Health Education System

Churchman defines a system as "a set of parts coordinated to accomplish a set of goals."[3] This definition applies equally to the health education activities of a family planning program or any other health program. At the same time, this health education program is a subsystem of a larger unit—the family planning program. The family planning program is, in turn, part of the larger health care network.

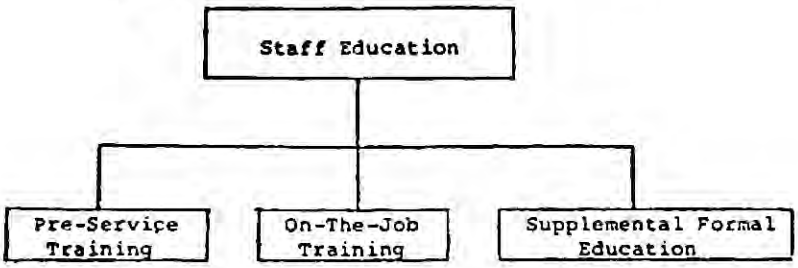
Just as the family planning health education program is a subsystem of larger health and medical systems, several subsystems can be identified within the health education program. This places health education somewhere in the middle of the hierarchy being discussed here (Figure 1). A look at the family planning health education program, with reference to the previously stated definition of a system, reveals two distinct subsystems: one which is directed toward the education of the staff, and a second which is directed toward the education of the client. These two subsystems are ideally found in all health education programs which are linked to a larger program supplying clinical services.

Figure 1—The hierarchy of systems which includes the health education activities of a family planning program



Note: In some cases, family planning is a free-standing system and is not subsumed under an Ob-Gyn or MCH program.

Figure 2—Components of the staff education subsystem



The Staff-Education Subsystem

The staff-education subsystem may be thought of in terms of three major parts or components, each focusing on a slightly different goal. These three components are preservice training, on-the-job training, and supplemental formal education (Figure 2).

Preservice training is aimed at preparing the professional or the paraprofessional to take up his or her role within the system. This includes training courses of various lengths dealing with technical aspects of family planning and related subjects, field work and orientation to the program. It does not include education which prepares the person for his or her general role as a health professional —such as medical or nursing school education.

On-the-job training, the second component of this system, addresses itself to skill perfection on the job. In practice, this has been an informal process confined mainly to exchanges between staff members or work with minimal supervision. However, it has the potential of being a directed activity which is built into the program through such activities as weekly staff meetings at which reports of activities are made by various staff members, case histories are presented or problem-solving exercises are undertaken by the group.

Supplemental formal education, the third component of the staff-education subsystem, is designed to bring something new to the system from outside resources in the form of information, techniques or interpersonal dynamics. Seminars, conferences, and lecture series bring the staff information about a new method of birth control or a new educational approach. Sensitivity sessions are intended to bring increased communication and cooperation among the staff members or a deeper understanding of the clients and their problems.

The staff-education subsystem is of sufficient importance and scope to warrant lengthy, separate attention. Only the client-education subsystem will be considered in depth in the present paper.

The Client-Education Subsystem

One way of looking at client education is in terms of four major goal-directed components: recruitment, information-giving, instruction, and follow-up (Figure 3).

Because educational approaches as well as the dissemination of many bits of information are often duplicated within the various components of the system, it becomes necessary, for the sake of clarity, to set guidelines to determine under which component activities are to be classified. This is best done by defining the components in terms of the goal or goals each is trying to achieve. It is therefore necessary to look at one of the over-all goals of the family planning system. Ideally, it is to enable those in need to adopt family planning. Adoption of a

health action is not a new concept for health educators to consider. We have long been interested in the steps that a client goes through when adopting a new health practice: awareness, interest, trial, evaluation, and adoption.[4] It is clear that any program with the ultimate goal of adoption must take into consideration the usual prerequisite steps, making the client's transition toward the goal as easy and natural as possible.

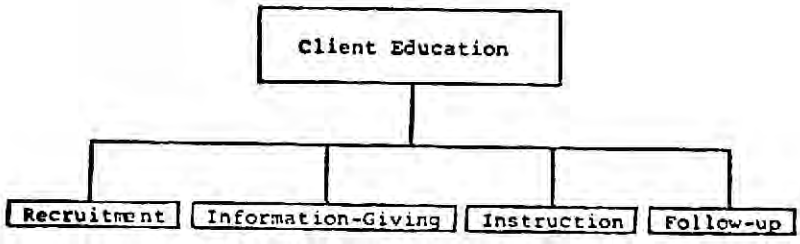
Urban has outlined the adoption process as it applies to family planning.[5] Here the relationship between the components of the family planning health education program and the adoption process will be discussed so that the components can be clarified in terms of their function. The components can then be broken down into their activities.

Recruitment activities are aimed at achieving awareness and stimulating interest in the potential client. Depending upon the previous level of awareness and interest of the individual, the recruitment education campaign is designed to bring about an awareness of family planning—its possibility and benefits, the availability of specific family planning services or specific contraceptive methods. It is also aimed variously at creating interest in family planning in general, in seeking information, in attending a family planning clinic or in trying a specific contraceptive method.

Preliminary recruitment activities may merely provide an information base for future decisions concerning clinic attendance or contraceptive acceptance. Some activities may not be aimed directly at the potential client but at others such as opinion leaders who may be instrumental in future recruitment endeavors. Many recruitment activities are aimed at gaining general support in the community for family planning or to create a favorable environment in which the program may function. The recruitment messages are organized and presented in such a way as to raise the individual's level of interest to the point of his or her wanting to come to a family planning clinic. In systems jargon, recruitment activities are ultimately designed to bring clients from the environment into the system through mass media efforts or home or institution visits.

The *information-giving* component is aimed at helping the client make the transition from the interest stage to the trial stage. Since, in most cases, the recruitment component and the information-giving component are carried out by different personnel and communication between the two is often poor, the staff member responsible for pretrial information-giving cannot assume that the steps of awareness and interest have been negotiated completely. It is fairly certain that the people presenting themselves at a family planning clinic are already aware of family planning and the clinic's existence and are interested in attending it. However, a person may not be equally aware of all the available methods of contraception. His or her apparent interest in one particular method may be due to a lack of awareness of the others.

Figure 3—The components of the client education subsystem



As part of the information-giving component, the client should be made aware of the major methods available so that interest in a particular method is based on knowledge rather than ignorance of the alternatives. He or she may then choose the method which is best suited to his or her particular situation.

Subjects covered may include information about menstruation and reproduction as well as about the relative efficacy, medical and social advantages and disadvantages of the different contraceptive methods and the major contraindications to their use.

Some of this information is offered to the client during the course of the other three components to some degree, but on those occasions it is presented to advance different goals. As part of the information-giving component, it is specifically intended to stimulate, encourage or support the client to the point where he or she is ready to try a particular method. The information-giving component directly precedes method selection.

Once the decision to try has been made, the *instruction* component provides education in the long-term use of the particular contraceptive method. Some information which is generally classified as instruction may be given as early as the recruitment component. Information on method use is often given during the information-giving phase in order to point up the advantages and disadvantages of the various methods. This instruction-like information was given at that time to facilitate method selection. It is doubtful that the client would remember enough of the detailed instructions for effective use of his or her method of choice. A separate and systematic explanation of how to use the method, a description of common side effects, and a suggested or appointed time for next clinic visit would make the client's trial and evaluation phases more positive and is more likely to foster eventual adoption.

For instance, as part of both the recruitment and the information-giving components, it might be mentioned that there is a pill which, when taken once a day, prevents pregnancy. The one-a-day concept was introduced merely for descriptive purposes. However, during the instruction phase, the fact that the pill must be taken once a day, every day for 20 or so succeeding days is one of the central messages.

Follow-up has two general purposes: one educational, the other administrative. Educationally, follow-up is designed to facilitate continued practice of contraception or use of a specific contraceptive method. Administratively, follow-up is designed to advise the program staff of the client's status, that is, continuing practicer of contraception, continuing user of the method prescribed or dropout.

Health education follow-up procedures can be separated into three categories: clinic-centered—both routine and problem-oriented—outreach follow-up in the community, and general follow-up.

Routine health education follow-up is that which is associated with the regularly scheduled revisits, such as a month, six months, a year or more after the initial prescription of the contraceptive. When the client returns to the clinic, he or she is seen by clinic personnel who try to determine whether there have been any problems, whether the contraceptive has been used properly, and whether the client has any questions. Ideally, this type of inquiry is built into the formal follow-up procedure of the clinic.

Problem-oriented clinic follow-up is similar to routine follow-up in that it takes place in the clinic when the patient returns for a revisit. However, this revisit is not of the prescheduled variety, but is made when the client encounters a problem with the contraceptive and returns to the clinic as a result. When necessary, the physician and others attack the problem medically while the psychosocial aspects are dealt with educationally.

Outreach follow-up takes place when an attempt is made to contact clients outside the clinic setting. Notice may be sent to the client that he or she is due for a clinic visit. Some programs telephone clients who fail to keep their scheduled appointments or send out letters or home visitors. Some researchers are attempting to identify predictors of contraceptive dropouts[6,7] so that potential dropouts may receive selective individual or group, supportive follow-up. For example, it may be discovered that in certain areas women who are not working or do not have a fixed schedule tend to discontinue the use of the pill. The program in that area would arrange for periodic individual follow-up of those clients who stated at the initial visit that they were not working, in order to encourage them to continue contraception and to help them to routinize pill-taking.

General community follow-up is aimed at society in general. It is designed to legitimize family planning and give it an air of respectability in order to make continuance of contraception the socially approved behavior. General follow-up messages are very similar to recruitment messages and it is often difficult to determine to which component a given activity belongs. General follow-up messages are intended to help the family planning users in the community feel that they are doing the right thing and to remove psychological barriers to continued use. On the other hand, recruitment messages are aimed at interesting nonusers in family planning. Often the same message or activity can be made to serve the two purposes.

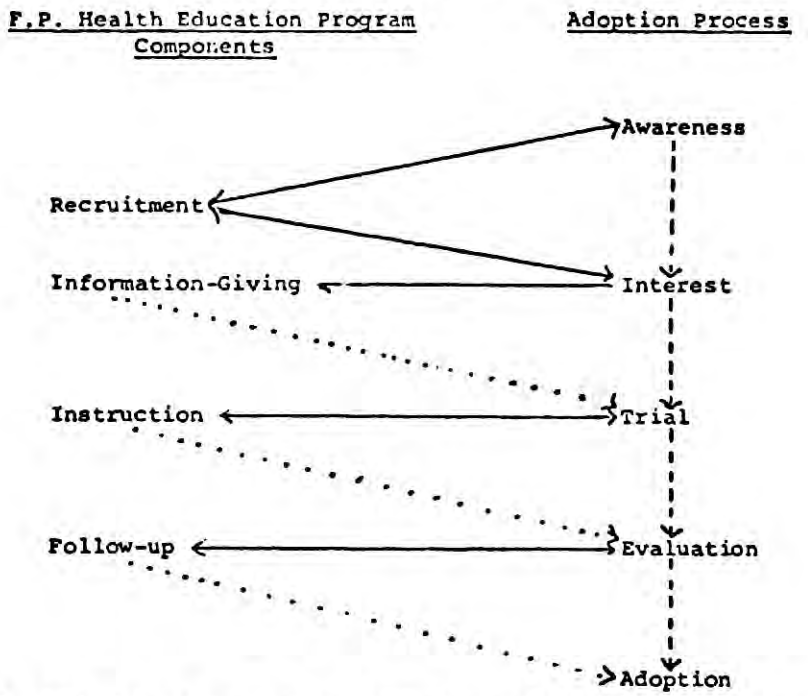
General follow-up can be approached in a number of ways. Issuance of a favorable family planning policy by a government lends support to family planning on a national level while rallying of public opinion and endorsement by community leaders achieves the same purpose on a more local level. Peer support can be used to supplement individual motivation through the use of success stories of satisfied users on the radio and in the newspapers. Antirumor campaigns aim to allay fears among the family planners in the community.

The extensiveness of the follow-up component can vary depending on the method in question and the definition of adoption used by the program. With the more permanent methods such as sterilization, adoption is synonymous with trial. Routine follow-up to foster continued use is not necessary since adoption has taken place. However, problem-centered follow-up may be necessary to aid the client in psychologically coping with his or her sterilization. Not only is such follow-up beneficial to the individual but it is also beneficial to the program. It minimizes the amount of negative publicity and rumor that is the usual by-product when people experience dissatisfaction during the trial and evaluation phases.

With the reversible methods, adoption is not synonymous with trial. Definitive adoption of reversible methods is difficult to define and even harder to measure.[8] Customarily, adoption of contraception has been defined in terms of a minimum period of continued use, a more or less arbitrary assignment made for administrative purposes. The employment of a period of continued use to define adoption does not take into consideration that adoption is a mental commitment to continue the practice of contraception. The period between the initial trial of the contraceptive and the commitment to continue use varies significantly between individuals. Despite this variation between individuals and by methods, and because of the very fact that there is almost always a time lag between trial and adoption, an organized follow-up component should be incorporated into the family planning health education program if the program administrators wish to have a program which fully considers the educational needs of the client.

Follow-up activities, then, by lending

Figure 4—The relationship between family planning health education program components and the adoption process



Key: ---> Indicates usual or most common time sequence but inevitable progression to the endpoint is not implied (nor is it inevitable that all steps are taken or in this sequence.)

<----> Program activities are aimed at producing favorable passage through a phase of the adoption process. Progress along the steps of the adoption process, in turn, indicate readiness on the part of the client or potential client for further program effort.

· · · > Program activities pave the way for progress on to another step in the process of adoption.

support and giving information and instruction when necessary, are intended to help the client make the transition from the first physical attempts at trial through a positive evaluation period to the mental commitment of adoption.

Figure 4 shows the relationship between the components of a family planning health education program and the phases of the adoption process.

Breaking Down Program Components Into Specific Activities

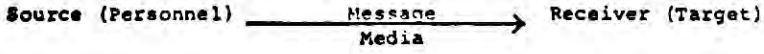
Describing the program components in relation to the adoption process helps to identify the relevant educational goals of each of these components. Once the goals are identified, the program evaluator appropriately asks: What are program activities of each of these components which are aimed at achieving the related goals?

Because of the creativity of family planning programs around the world in devising new approaches to health education, the list of possible activities is extremely long. However, these activities can be represented for descriptive and comparative purposes, using the elements of a model well-known to health educators—the communications model represented diagrammatically in Figure 5.

Each activity of a program component can be described in terms of at least one

characteristic of each element of the communications model[9]—personnel, media, message and target—with the addition of place of communication. In describing the activity, all relevant characteristics of each of these elements are listed in order of their importance or emphasis. For instance, a recruitment activity aimed at patients in postpartum wards would be represented by Figure 6. The most important or novel characteristics of the activity are fully capitalized. On the other hand, another recruitment activity in which paraprofessionals make neighborhood visits might be portrayed as in Figure 7.

Figure 5—A model of the communication process

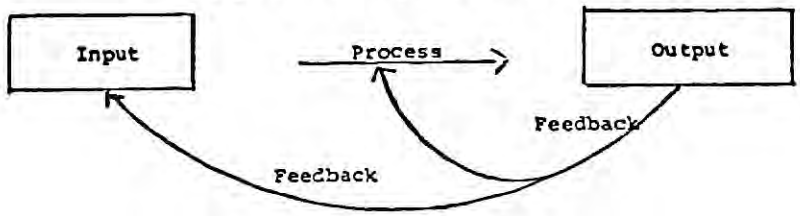


Figures 6 and 7—Representations of family planning health education activities using a modified communication model

A. Personnel	B. Media Characteristics	C. Message Bits	D. Target Characteristics	E. Place of Communication
1. Nurse-Midwife (1)	1. Face-to-face 2. One-to-one 3. Discussion	1. FAMILY PLANNING INTRODUCTION 2. CLINIC LOCATION 3. MOTIVATIONAL MATERIAL 4. Contraceptive Methods	1. POSTPARTUM	1. HOSPITAL WARD

1. PARAPROFESSIONALS (9)	1. Face-to-face 2. One-to-one 3. Discussion	1. FAMILY PLANNING INTRODUCTION 2. CLINIC LOCATION 3. MOTIVATIONAL MATERIAL 4. Contraceptive Methods	1. PRE-NATAL 2. POSTPARTUM	1. NEIGHBORHOOD

Figure 8—A simple systems model



As can be seen by comparing the two figures, the main differences between these activities are the type of staff members doing the communication and the location of the interchange. The target population has also expanded in the second example to include prenatal women as well as those who have recently delivered.

Once all activities of the recruitment, information-giving, instruction, and follow-up components have been identified, the evaluator can proceed to the measurement of these activities.

Some Measures of the Health Education System[10]

In the simplest systems model, *inputs* (or efforts) coming into the system are transformed into *outputs* (or products) through some *process*. The system is monitored and controlled through a mechanism known as *feedback*. This simple system model is diagrammed in Figure 8.

Inputs are the resources upon which the system may draw. These include manpower, facilities, equipment, and supplies, all of which are obtainable with money. Outputs are the goods, services, and information, which are produced by the inputs. The process is the manner in which the resources are mixed and activated to yield these goods and services.

The idea of feedback is one of the key concepts of systems. It is also the *raison d'être* for this framework, since feedback is the focused report of evaluation findings. The administrator can view the various parts of the system and their interrelationships, and can then, through feedback, modify the system where necessary to improve functioning through a deliberate, stepwise process. Using the sequence of events of feedback in a work system which produces a tangible product as an example, the feedback of a program whose product is service becomes clearer (Table 1).

Process is ultimately the principal concern of the evaluator and the administrator. Process is the dynamic functioning of the system. It describes which tasks and activities make up the program, which staff members perform them, when and in what order and in which location they are performed. Although process can be described objectively by means of such techniques as time studies, flow charts, and the like, no *a priori* judgment can be made as to its quality. Indicators of the quality of functioning must be used.

When considering as a system a program which provides educational services, *inputs* are most commonly quantified in two terms: dollars and man-hours. Dollars are spent on building space, equipment, educational materials, personnel and the like. Man-hours can be used to produce material, hold clinic sessions, make field visits, and so forth. Input measures in and of themselves are more likely to be useful in program planning activities such as scheduling and budgeting. However, input measures are essential in the computation of the other evaluative measures to be discussed later.

One of the grossest indicators of a

system's functioning is its *output*. The outputs of the health-education system may include information, materials, or educational sessions, depending upon the level of the system which is being examined. In all but the simplest system, outputs from one part of the system become inputs of another part of the system. For instance, information may be broadcast to the public and is, in this case, an output. This information may, in turn, be combined with man-hours of work, some printing equipment and art supplies to produce a piece of educational material. This piece of educational material may later become one of the inputs of an educational session, and so forth. Most reports of service statistics are merely documentation of a program's output.

Obviously, merely holding educational sessions or passing out pamphlets is not the ultimate goal of the health education program. The goal is to produce change. When the observed change can be related to the system it is an *effect* of the program. Effects may be produced on two major levels: within the client or potential client, and within the family planning program itself.

Within the client or potential client, the desired effect is a change in the levels of knowledge of, attitude toward, and practice (KAP) of family planning. In other words, the change is in terms of movement in the direction of the steps of the adoption process. At present, methods of quantifying these internal changes within individuals have not been sufficiently refined for mass measurement. Before-and-after KAP studies allow comparison of specific items such as change in ideal family size, change in knowledge and practice of various contraceptive methods, and so forth. However, techniques have not yet been developed for

Table 1

The feedback process of a work system[11]	*Program evaluation*
1. Specifications of desired results are "presented" to the primary processing system.	1. A program proposal is drawn up including the goals of the program.
2. The primary system performs its processing or sequencing.	2. The program is carried out.
3. Measures are made of the output from the processing.	3. Measures are made of indicators of the program's functioning. (Output measures are not the only indicators of program functioning.)
4. The output measures are compared to the desired results.	4. The indicators are compared to the desired results or with indicators of other activities or individuals attempting to achieve the same desired results.
5. Deviations from the desired results are identified compared to the confidence limits for the system.	5. Deviations from the desired goals are identified and compared to the allowable deviation for the systems or activities or individuals and are ranked in order of their performance.
6. Action is taken—if needed because the output measures exceed the confidence limits—to change the specifications given to the primary system, or to correct the primary system itself.	6. Action is taken in the form of program planning—if needed because the indicators exceed the confidence limits or some activities or individuals show superior performance—to modify the goals of the program or to modify the program itself.

identifying change from awareness to interest, from slight interest to intense interest, from trial to adoption, or to determine exactly which program activity produced the change.

The change in the family planning program itself which is most often attributed to health education activities is decreased or, preferably, increased levels of utilization of services, a possible product of recruitment activities. In order to be considered an effect, again, this increased utilization must be related to the program or specific recruitment activity being evaluated rather than to some other activity or even an artifact having nothing to do with the program.

Relating change within the system to the program is somewhat easier than relating change within the individual to the program. Let us suppose that we wish to measure the effects of paraprofessionals working in the community as recruiters. It cannot be assumed that all clients coming to the clinic from a given neighborhood have come because of the efforts of the paraprofessionals. These women may be responding to some mass media appeal or to the suggestion of friends or neighbors. A number of ways may be used to relate this increase in clinic recruits to the efforts of the program. Over time, it is possible to compare the recruitment trends of an area which receives the program input with another which receives no program input. On a more limited basis, it may be possible to compare lists of names of people contacted in the neighborhoods by the paraprofessionals with lists of clinic attenders. Alternately, coupons may be given to potential clients when visited in their neighborhoods, to be redeemed at the clinics. A less accurate but easier method than these already mentioned of relating program input to effect is the old stand-by question on the intake form: "Where did you hear about the clinic?"

When effect measures are related to the fulfillment of a stated goal or the satisfaction of a need, another indicator known as *effectiveness* is produced.[12] That is to say, the program's effectiveness is the degree to which it has fulfilled its stated goals or eliminated specific needs. In terms of utilization of health education services, one measure of effectiveness is the number of information sessions given as compared to the number planned (actual/planned). Perhaps a more useful comparison is the number of clients actually recruited in relation to the recruitment goal. Similarly, it would be expected that close to 100 per cent of the clients coming to the clinic would try some type of contraceptive method as a result of the information session. The number of new clinic attenders as compared to the number of new contraceptive acceptors could be an indicator of the effectiveness of the information sessions.

It is important not to get carried away with the use of such indicators. As previously stated in the discussion of effects, it is difficult to attribute an individual's action to a single program activity or even to the program as a whole. The action may merely be reflecting personal readiness and motivation rather than program input, process or output. If goals have been arbitrarily set, effectiveness measures indicate only the degree to which the system has fulfilled these arbitrary goals and do not necessarily indicate the degree to which the system itself is functioning in a healthy manner.

The final measure of program functioning to be considered here is *efficiency*.[13] Efficiency, in systems terms as well as mechanical terms, is output/input. In system terms, however, efficiency can be expanded to include effect/input and effect/output as well. It yields evaluative measures such as cost per session held, cost per person reached, cost per pamphlets produced or cost per new acceptor achieved. Measure of efficiency may also include such things as man-

Figure 9—Framework matrix for use in evaluating the health education activities of a family planning program

Components of the Subsystem	Evaluative Measures				
	Input	Output	Effect	Effectiveness	Efficiency
Recruitment Activities for Clinic Use or Other Services					
Information-Giving Activities for Contraceptive Method Selection					
Instructional Activities for Contraceptive Method Use					
Follow-up Activities for Continuing Satisfaction and Contraceptive Adoption					

hours of work per person recruited, man-hours of work per pamphlets distributed, and so on.

In summary, then, five measures or indicators of functioning have been suggested to correspond to the components of the health education program: input, output, effect, effectiveness, and efficiency.

The Framework Matrix

All of the elements for the proposed evaluation framework have been presented. They can then be put together in a simple matrix form so that the entire program can be laid out in such a way that a comprehensive evaluation can evolve. This is done by listing all of the activities of each component of the program along a vertical axis and listing the possible quantitative measures or indicators along a horizontal axis as in Figure 9.

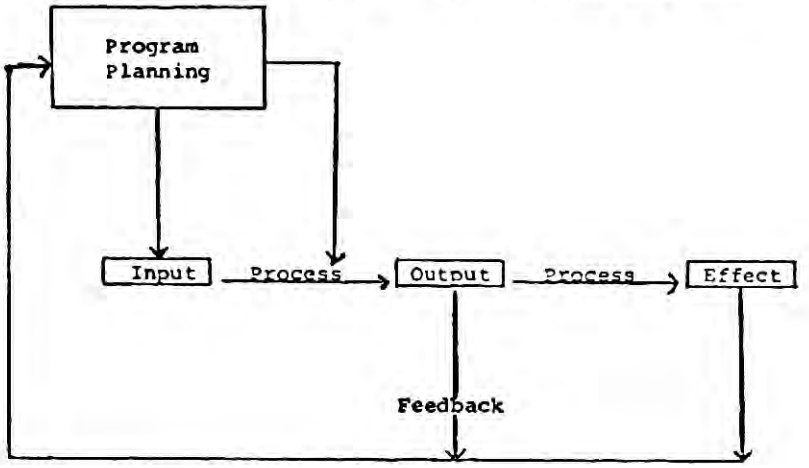
Selection of Measures for Evaluation of the System

When filled in, the framework could yield an enormous number of measures. It is obvious that, although employment of all of these measures would yield a comprehensive evaluation of the program, it would be virtually impossible to handle, not to mention being impractical and of dubious value for most programs. Only a limited number of measures can and should be selected for program evaluation. The number and nature of these measures are determined by several conditions.

Measures selected for evaluation should have implications for program planning if they are to be worthwhile. Some of the questions which the evaluator should ask when selecting measure are: Does this measure tell me what I want to know about a facet of the program? Is it feasible for this facet of the program to be changed? Is this facet of the program important enough to merit the effort? The relationship between evaluation and program planning can be seen in Figure 10.

In two ways the problem of limited resources is a determining factor in the selection of evaluation measures to be employed. The administrator must consider the money and manpower necessary to carry out the evaluation itself. It is

Figure 10—The feedback-program planning cycle of a system



generally easier to collect data from service statistics than from community surveys. It is also more practical for programs to use measures which have been developed previously than to engage in the costly undertaking of employing researchers to develop and test new measures.

Secondly, in deciding which input item to measure, it is necessary to know which resource will most probably be in the shortest supply for use in the next program year. If there is to be a cutback in the budget of this program, dollars of input are naturally the most relevant concern and efficiency measures should be a function of cost. On the other hand, if the program is losing staff who are not being replaced or if it must reach more people but sufficient additional staff cannot be recruited or trained, man-hours will be the most relevant unit of input and the focus will be on the efficiency and effectiveness of various personnel.

Measures to be used in a given evaluation generally address themselves to aspects of program which have been designated "high priority." These include new approaches, large-budget items and key activities.

All of the above factors must be considered when selecting or developing measures to be used in the evaluation. Even with all of these factors considered, spotty evaluation could result. The use of the framework adds an additional dimension to selection of evaluation topics and measures, that of ample program coverage. It allows the evaluator to see more clearly which areas of the program have and have not been planned for in the evaluation so that he may fill in the gaps.

Summary

In this paper, an attempt has been made to build a pragmatic framework for the evaluation of health education activities of a family planning program. It was suggested that the health education system of a family planning program can be seen as consisting of four components: recruitment of clients, information-giving for method selection, instruction for method use, and follow-up for continued satisfaction and continued use. These components were defined in terms of their relationship to the five-step adoption process which the client usually experiences. Examples were given of some of the health education activities in current use which comprise each of these

components. Health education activities grouped according to these components form the vertical axis of the framework.

The systems concept was briefly introduced and five types of measurements —input, output, effect, effectiveness, and efficiency—were defined and described. These five types of measurements form the horizontal axis of the framework.

After the elements of the framework were defined and described, a visual representation of the matrix was presented. A general guide for selecting the measures appropriate for a given activity was described. Thus an evaluator, who wishes to use the framework for a comprehensive and systematic evaluation of health education activities of a family planning program, can fill in the matrix.

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Communications

Tailoring Information and Education Material To Specific Audiences Is Crucial for Success

Before embarking on a family planning information and education (I & E) program it is essential that program operators determine who comprise the primary, secondary and tertiary audiences for such a program, and what are their most urgent specific informational needs, advises J. Mayone Stycos, director of the International Population Program at Cornell University. Stycos, a sociologist who has for years studied the family planning programs of many Latin American countries, and specifically, their informational content, urges that every informational and educational message be tailored to meet the precise and varying needs of each of the audience groups. While the focus of his study is on the experience in developing countries, many of Stycos' observations have relevance for the informational efforts of U.S. family planning programs. Given the economic and manpower constraints governing most family planning programs, Stycos believes that program operators should ask themselves the following questions as they examine their I & E efforts: How many resources are being allocated to each category at whom messages are being directed? What priorities should be established for I & E activities? How cost-effective is the I & E activity for each group?

Stycos believes that the primary audiences, with the highest potential receptivity to family planning, include clinic *first admissions and revisit patients*, followed by *postpartum patients* and *newlyweds*, whose receptivity may be more moderate. Low-income women (who may not necessarily be in the groups specified) are also a primary audience. Included in the secondary audience group are the program and government staffs directly involved in family planning. Both are highly receptive to I & E efforts. In the tertiary group with high receptivity are family planning program boards and officials directing government activities.

Stycos' observations on the messages addressed to some of the groups and his recommendations for improvement or change may be suggestive to those responsible for I & E programs in the United States. Of the primary groups he makes the following comments:

• *First admissions*. Women who come to a family planning clinic for the first time "are often the victims of too much rather than too little information." Much of it is "irrelevant and some of it is productive of anxiety. . . . Women come to clinics knowing what they want and it is not complicated: they want to stop having children. They want something that will do this without harming them. They do not care about reproductive physiology, demographic trends, responsible paternity, or sex education. They are nervous about what is going to happen to them, anxious to get it over with as quickly as possible, and in no mood to absorb a lot of information." What they need, according to Stycos, is reassurance, plus information about what side effects to look out for and about why they should return to the clinic for regular follow-up. "In many clinics today, they do not get enough of the information they need, and get a lot they do not need instead." [See: "Clinics Teach Less Than Patients Learn," *Digest*, Vol. 1, No. 2, 1972, p. 13.]

• *Returning patients*. Since many patients never return for follow-up, the woman who does come back is obviously highly motivated. "This is the 'satisfied customer' so crucial to every successful sales campaign," Stycos points out. As such, she should be encouraged to act as salesperson for the program. This is especially important since "surveys invariably show that most new patients hear about the clinic by word of mouth, mainly from clinic clientele." [See: "How to Tell People About Family Planning," *Digest*, Vol. 1, No. 1, 1972, p. 6.] The author notes that since returnees "are usually subjected to considerable waiting periods in the clinic, the time could usefully be filled by teaching them how to spread the word about both the clinic and non-clinic sources of contraception. If there is additional time," he adds, "they could receive instruction, preferably automated, on reproductive physiology, maternal and child health [and] nutrition . . . matters of importance in their own right. . . ."

• *Postpartum patients and newlyweds*. Both groups are "motivationally receptive" to family planning education, and here the aim should be to sell the program. Postpartum patients are an "ideal group," since they are "conveniently agglomerated and relatively undistracted. Moreover, the act of maternity and the hospital setting makes explicit family planning information appropriate, where it might not be so for diffuse audiences." With newlyweds and new mothers the emphasis should be on "a 'spacing' goal." Stycos maintains that "a special advantage of reaching such groups is that they are still at an early point in fertility. . . ."

• *Low-income families*. Stycos notes that "the greatest number of potential clinic clientele" is among women of reproductive age who are in the lower income category, as in the United States. One of the major tasks of I & E programs is to identify or create special interest groups when families are "widely separated spatially, difficult to identify and have highly diffuse interests or characteristics." Since many low-income women work, efforts to reach them should be made through labor unions, factories or offices, and the large farms where, in the United States, they may work as migrant labor.

Of special relevance to the United States are Stycos' observations concerning family planning staffs, whom he views as a secondary audience of high receptivity to I & E, and boards of directors, described as a tertiary audience.

• *Staff*. While most staff members at all levels have been well trained in whatever technical matters they must handle, Stycos observes, "what has been almost totally neglected has been the area of interpersonal relations. Given the vast social distance between doctors and patients, the potentially traumatic experience of the pelvic examination, the sub-strata of fears about contraception characteristic of many women who reach the clinic, and the high rates of dropouts, much more systematic training of staff in human relations is needed—training both in staff-to-staff and staff-to-patient relations." It is especially important, he emphasizes, to improve staff performance in health agencies (such as hospitals and health departments) where family planning has been added to existing services and is perceived as having "the least medical glamour, with the least relevance to curative medical methods. . . ." Family planning is "likely to get lost in crowded general health clinics," he warns.

• *Boards*. "No systematic and specific efforts at [board member] education have ever been attempted," and the "educational mandate is clear," writes Stycos, when the range of problems policy-making boards must address is considered. These include: how to obtain financial support, what the relationship with government should be, "the need to broaden the base of policy decision-making, the need to explore non-clinical alternatives to contraceptive services, and the need to balance medical and motivational elements in programs." To assist them in grappling with these problems, they should be supplied, Stycos believes, with information about "demographic, economic and environmental implications of . . . family planning programs; comparative family

From Family Planning Digest 2:6 (1973), 4-5.

planning approaches around the world; technological advances in birth control techniques and program administration; private resource development methods; and the aims, structure and history of their local programs."

It is important to reach health, education and welfare services professionals, Stycos believes, because of the multiplier effect they can have as disseminators of information. He describes them as only moderately receptive members of the secondary audience group, but believes the effort to reach them with I & E messages is important because of the relevance of family planning to their professional objectives.

Stycos urges concentration on efforts to inform and educate politicians and government officials about family planning since they are important in determining the acceptance or rejection of family planning as an appropriate concern of government and in determining what priority it will have. "Their receptivity to family planning depends both upon its perceived political assets and liabilities, and upon its perceived role in national economic and social development," Stycos points out. He observes that "family planning proponents have tended to sophisticate themselves about the contributions of birth control to long-range development, but have been singularly silent, and possibly naive, on its short-range political advantages . . ." He believes government officials are now open to I & E efforts "if these are intelligently directed."

Just as the messages must be appropriate to the requirements of each group so, too, must there be discriminating use of the various communications media. He believes that printed materials are the most important means for reaching most of the target groups, and that "no first admissions or returning client . . . should leave . . . without specifically designed printed materials aimed at repeating and clarifying what has been said in the clinic, on the one hand, and which can be passed on to husbands and friends on the other."

The aim of all information and education programs, Stycos concludes, is to increase "public demand for services," raise the commitment "of the decision-makers who ultimately determine the supply," and improve "the efficiency and commitment of the family planning personnel who deliver the services."

Source

J. M. Stycos, "Targets, Messages and Media—Family Planning Information and Education in Latin America," paper prepared for the Executive Committee of the Western Hemisphere Region of the International Planned Parenthood Federation, 1973.

MODULE MANAGER'S GUIDE

This guide is provided as an aid to trainers who wish to use this module with groups. It contains a number of suggestions for "managing" the learning process of small groups (6-8 participants) when the module is the principal, or only, learning material.

BASIC ASSUMPTIONS ABOUT LEARNING

This module is based on certain assumptions about adult learners with professional roles. We believe that learners of this type bring with them to the learning situation a rich background of ideas and experience that must be drawn out and incorporated into the learning process. We also believe that these individuals can profit from the experience of others. We have found in testing the material that participants can and should take active and leading roles in the learning process. We have also found that individuals learn at different rates and in different ways. Thus we emphasize the learning of content through reading (which can be a self-paced activity), as well as a variety of other methods (group discussion, activities, exercises, problem cases, and examples).

THE MODULE MANAGER'S ROLE

It is the module manager's job to coordinate these activities, to encourage discussion, to provide feedback on progress, to assemble and arrange resources --in general, to keep the process running and on track.

This is not a traditional teaching role. While the module manager should have expertise in clinic education and may share this with participants through discussion, question asking and answering, and even an occasional small lecture, the manager is not the major source of information and ideas. This role is shared by the participants and the module text.

To prepare for using the module, the manager should read it through carefully, completing all exercises and activities. The next step is to evaluate the available material in terms of the needs and capabilities of intended learners. Next, the manager should plan a learning program using those aspects of the module found useful and supplementing them with local resources. A bit of rewriting and adaptation of module material is often required at this point. Additional local resource people can be brought in.

This module, like all teaching material, should be viewed as a constantly growing and changing resource for learning. A major part of the manager's role is to foster and manage this growth and change. In many respects, a good module is never "finished."

BASIC INSTRUCTIONAL MODEL

The components of each unit are arranged to correspond with our view of one effective learning process. This process, which has evolved through repeated testing of the material with international learning groups, is outlined below together with the module components that reflect each stage.

Learning Stage	Unit Component
Understanding of what is to be learned	Unit objectives
Stimulation of learner's own ideas and experience for motivation and integration into the learning experience	Getting Started with Your Own Experience
Acquisition of new concepts	Notes from the Experience of Others
Practice with concepts	Exercises, examples, questions in "Notes" section
Review	Unit Summary
Active Practice in Groups	Something to Do
	Discussion sessions
Feedback to learner	Self-Tests

In general, we recommend that each unit be approached in generally the same way, although variation is important to help maintain learner interest. A general sequence of activities is given below, together with some optional activities.

	Options
1. Learner reads objectives	Group discussion of objectives
2. Learner completes Getting Started With Your Own Experience	Group discussion after completion
3. Learner reads "Notes," completing exercises, etc.	Can do alone or in groups
4. Discussion of "Notes"	
5. Learner completes Something to Do	
6. Discussion of exercises and activities in Something to Do	

7. Learner completes Self-Test	May be reviewed by module manager

We have used this model, and the options, with some success in Honolulu.

OVERALL SCHEDULE

It is difficult to construct a detailed schedule of the module for general use in a wide variety of settings. However, a basic schedule is suggested below. Managers should modify this in light of their own experience.

DAY ONE	Morning	1. Introduction of module--1-1/2 hours
		2. Read Unit I--1-1/2 - 2 hours
	Afternoon	3. Complete Unit I
		4. Discuss Unit I
DAY TWO	Morning	1. Read Unit II--1/2 hour
		2. Complete Exercises #1 and #2--2 hours
		3. Discuss Exercises
	Afternoon	4. Complete and discuss Activity A
DAY THREE	Morning	1. Read Unit III--3 hours
	Afternoon	2. Complete Activity B--2 hours
DAY FOUR	Morning	1. Read Unit IV--4 hours
	Afternoon	2. Complete Activity C--2-1/2 hours
DAY FIVE	Morning	1. Read Unit V--1/2 hour
		2. Complete Activity D--1-1/2 hours
		3. Read Unit VI--4 hours
	Afternoon	4. Complete Unit VI and discuss problem cases
		5. Complete Activity D--2-1/2 hours
DAY SIX	Morning	1. Read Unit VII--1-1/2 hours
		2. Complete Activity F--1-1/2 hours
	Afternoon	3. Read Unit VIII--2 hours
		4. Complete Activity G--1-2 hours
DAY SEVEN	Morning	1. Read Unit IX--1 hour
		2. Complete Exercise #3--1-1/2 hours
		3. Final review session--1 hour

This is a reasonably light schedule. The total number of days required can be reduced by having evening reading assignments. By doing this in Honolulu we have administered the module in five full days.

ACTIVITY AND EXERCISE INSTRUCTIONS

Guidelines and ideas for conducting module activities and exercises are given below.

ACTIVITY A: PHOTOGRAPH ANALYSIS

This is one of the most important, as well as most popular of the Activities. It is used in the early part of our program for several reasons: (1) It gets a lot of in-depth participant involvement; (2) it gets participants used to the idea of Activities in a training program; and (3) it presents a broad overview of the rest of the module since it covers 7 of the 9 major topics of the module. At the same time, it is a way to stimulate participants to want to learn more in-depth about each of those major topics.

The photo-analysis technique has been used instead of a visit to a clinic, and we have had much better results for a variety of reasons.

1. Past experience in our own and other training programs has shown that clinic visits are largely a waste of time, since clinics are seldom set up to provide learning to short-term visitors, especially for groups of three or more at one time.

2. This approach allows us to emphasize careful and detailed observation.

3. There is opportunity for participants to openly and freely exchange ideas on a topic.

4. It is much easier to arrange and control than a clinic visit.

5. Using photographs from several places and countries allows a wide selection of educational situations to be shown. Photographs may be obtained locally from family planning organizations. Affiliates of the International Planned Parenthood have excellent photo resources.

6. Most importantly: It is an easy exercise to duplicate in many places.

ACTIVITY B: DEFINING THE MESSAGE

The most important part of this activity is step 3. If you wish, or if you are in a hurry, it is suggested that you only do step 3. The Appendix of this module has some "answers" to the questions of step 3. Participants should be asked not to look at them, however, until they have already written their own answers in the answer column of the module.

In writing the participants' message items on the blackboard, the activity leader may have to simplify the phrases, since participants sometimes call out items that are not stated in short, clear sentences that are understandable by village people.

ACTIVITY C: CLINIC EDUCATION METHODS AND MATERIALS

In this activity there is a tendency for participants to spend too much time discussing the content of the material and not enough on how to utilize the material. (This is perhaps because the participants last activity emphasized content.) The leader should, therefore, turn the discussion somewhat to utilization.

This demonstration can be done with the existing materials which are available in most countries. In addition, the materials used as examples in the module can be obtained from the international sources indicated in the text of Activity C.

This activity can also be combined with a "brainstorming" session. That is to say, it can be an opportunity for participants to suggest and discuss a wide variety of innovative educational efforts that frequently occur to them during the course of the activity.

ACTIVITY D: DISCUSSION QUESTIONS ON THE PHYSICAL SETTING AND ARRANGEMENT OF THE CLINIC

There are two parts to this activity. In the first, participants list physical things about the clinic which can be adjusted to improve education, as well as showing how these can be adjusted. We suggest that after participants complete the list as individuals, small groups review their lists and report back to the full group, which in turn makes a summary list on the blackboard.

The second part of the exercise asks participants to list ideas on the problems of dissatisfied clients returning to the clinic. Again, individual answers can be discussed in small groups, and synthesized.

ACTIVITY E: DEVELOPING YOUR OWN CLINIC STANDARD OPERATING PROCEDURES

This is a very important exercise because it provides an opportunity to review and practice together a number of techniques for planning introduced this far in the module.

Participants may complete the SOP form individually or in small groups. Completed forms should be discussed and synthesized. A good procedure is to build a SOP for the whole group.

ACTIVITY F: EVALUATION ROLE-PLAY

The Activity leader must be sure to instruct the volunteer "client with the new IUD" to play the role correctly; to act as a typical villager: Not wanting to hurt the feelings of an evaluator. Answering only "yes" or "no" if given the opportunity by the evaluator. The main purpose of this is to stimulate the teams to develop the kinds of questions which will find out exactly what the client knows or does not know.

ACTIVITY G: DESIGNING A CONTINUING EDUCATION PROGRAM

Like other activities, this activity calls for individual or small group completion of forms, small group discussion and comparison, and possibly a synthesis list of ideas on the blackboard.

EXERCISES #1 AND #2 - UNIT I

These exercises are important practice. They should be done individually, then discussed and compared.

EXERCISE #3 - UNIT IX

This exercise can be made more fun by having selected participants present their strategies in a role play. Selected participants play the role of suspicious, unconvinced administrators. It is also possible to have other participants viewing the role play act as a "jury," giving a "verdict" of successful or not successful--and why--at the end of the presentation.

OPTIONAL ACTIVITIES

Two additional, optional activities are listed below.

ACTIVITY H: FEEDBACK SESSION

Purpose: Feedback session from participants to staff on the usefulness of the module

Time: 1 hour

We will appreciate very much your help in improving this module. Please make your comments, keeping in mind that we want to improve it for use in two separate ways:

1. For use in Honolulu in future Modular Programs.

2. For use by professionals just like yourself, who want to use some or all of the module in training their own colleagues and staff at home.

Your comments therefore should be prepared with a reference to one or the other of these two uses.

Please, then, come to this session prepared to answer the following questions orally in the feedback session.

1. Which parts were useful to you here in Honolulu? Why?
2. Which parts were not useful to you here in Honolulu? Why?
3. How can it be improved for use in Honolulu?
4. Which parts will be useful to you or others for training your staff at home? Why?
5. Which parts will not be useful at home? Why?
6. If you do plan to use some or all of this module at home, what changes will you have to make in order for it to suit your needs?
7. Other comments or suggestions of any sort?

End of Feedback Session, Activity H

ACTIVITY I: DESIGNING A MODEL CLINIC

Purposes:
1) To design, "construct" and "utilize" a model clinic.
2) To combine the knowledge and skills previously studied into an actual educational setting.
3) To work as a team on an integrated activity.

Time: 2 hours

Materials needed:
1) Two rooms (average size). One room per group.
2) Educational materials and equipment to be selected from Institute's Resource Collection or provided by participants.
3) Ten chairs, two or three tables, etc.
4) Paper, scotch tape, etc.

Procedure: Participants will divide into two teams, A and B. Each should select a leader. (You should divide up a day ahead of time in order to do some advance planning.) Each team will take the room provided and create the educational section of a model clinic. A floor plan can be drawn and client traffic flow traced on the plan. Chairs and desks will be arranged, posters or signs put up, materials displayed, etc., and plans for client education made. These preparations should be done in the first forty minutes of this two-hour session. In the second half hour, Team A should visit the "clinic room" of Team B, as though they were clients. New and follow-up "clients" should hear/see a ten-minute educational talk/demonstration presented by someone from Team B.

During the next ten minutes someone from Team B should describe to Team A why the clinic is set up in the way it is, and he should himself actually walk through the path that a client takes, commenting on what happens at each place in the clinic, from the time the client enters to the time she or he leaves. The next ten minutes are for questions or helpful suggestions that Team A may have for Team B.

When this visit to B's clinic is finished, then both teams will go to A's clinic and the process will be repeated, this time with Team A as the staff.

Keep timetables pretty rigid to allow each team its share of time. It will be necessary for each team to prepare somewhat the night before.

Remember: It's a two-hour exercise:

40 minutes for each team to finish its plans, prepare the room, the talks, materials, etc. Then Team A visits Team B.

30 minutes in the Team B clinic, to do the following things:

10 minutes for the clinic educational talk to the "clients" of Team A.

10 minutes for Team A person to tell Team B why the clinic educational system is designed as it is, plus do a walk through of the typical client in the clinic.

10 minutes for visiting Team A (the "clients") to ask questions or make suggestions that they, as "clients," have for the staff to improve the clinic.

Then:

30 minutes in Clinic A with the roles reversed.

30 minutes discussion, by the entire group, of practical problems and solutions encountered in the activity.

ADAPTING THE MODULE

The module itself is "modular": Each of the units can be used separately, or they can be used in various combinations depending on time available and needs of participants. In particular, Unit I can be used for a one-day workshop to make participants aware of the basic issues and concepts in clinic education.

In addition, each unit can be strengthened for local use by using local examples, modifying exercises, etc. The "Notes" sections can be expanded to include the experience of still "others" (in addition to the module authors).

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