Training of Counsellors for Adult Male Circumcision

SITE RESOURCE MANUAL

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DRAFT

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Agnes Musonda (SFH HQ)
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Joseph Masiye (SFH MC Site)
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Emily Waters (CIDRZ)
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Dr. Peter Mwaba
Permanent Secretary
Ministry of Health

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Introduction

In March 2007, WHO and UNAIDS recommended adult male circumcision (MC) as an effective HIV risk reduction measure. Randomized control trails conducted in South Africa, Kenya and Uganda demonstrated that MC reduced a man's risk of HIV acquisition by up to 60%.[1,2,3] In addition to reducing the risk of HIV infection, MC reduces a man's risk of syphilis and chancroid infections as well as human papillomavirus (HPV). MC has been shown to be a cost-effective risk reduction strategy that has the potential to significantly reduce the number of new HIV infections in Southern and Eastern Africa.[4,5,6]

Since mid-2007, the Government of Zambia has supported the implementation of adult MC services in the public, non-governmental and private sectors. As defined by the National Male Circumcision Strategy and Implementation Plan 2010-2020, the minimum package of MC services in Zambia shall include: informed, voluntary consent; pre-procedure counselling on HIV and STI transmission and risk reduction; pre-procedure MC counselling; routine counselling and testing for HIV; routine treatment of STIs and distribution of condoms; point of entry for other men's health services; safe medical services; and, post-operative counselling.

The complete training package was developed and piloted in August 2010 and was finalized based on feedback from representatives from the MOH, SFH, FHI/ZPCT II, Marie Stopes International, CIDRZ, CHAMP, and Corridors of Hope/ZHECT.

This site resource manual is intended to serve as a reference tool for staff at MC service facilities who inform and counsel men, women and parents on MC. However, it should not replace formal training for individuals providing MC counselling services and support to clients. Users of this manual should:

- Have undergone training in basic psychosocial counselling skills and experience using client-centred counselling techniques (preferred);
- Have technical skills and experience in HIV counselling;
- Be familiar with the national MC service package and service delivery protocols; and,
- Have undergone training in MC counselling.

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Why MC and MC Counsellors?

Slides:

Explanations:

Why Male Circumcision and MC Counsellors?

Purpose of MC interventions

Decrease the number of new HIV infections by increasing the prevalence of circumcision, as part of a comprehensive HIV prevention strategy.

Male circumcision interventions are expected to play a key role in turning the tide of HIV/AIDS in many countries in Eastern and Southern Africa, including Zambia.

How can we do this?

- Increase *access* to safe MC services;
- Increase *informed demand* for safe MC services;
- Ensure *safer sexual behaviours* among MC clients and partners of clients; and,
- Improve the *cost effectiveness, quality and efficiency* of MC services.

Why male circumcision?

When researchers compared HIV prevalence to MC prevalence, they found that the two appeared to be inversely related. Countries with a higher MC prevalence seemed to have lower HIV prevalence. Notice how Swaziland and Zimbabwe have high HIV prevalence (red), but have low MC prevalence (yellow).

In Zambia, we find a similar pattern. Here you can see that across provinces, as MC prevalence decreases, HIV prevalence increases.

Better research showed impact of MC on number of new HIV infections

- Conducted research to assess this theory:
  - South Africa—semi-urban
  - Kenya—urban
  - Uganda—rural
- After two years, found that:
  - Circumcised men → 2.6% HIV prevalence
  - Uncircumcised men → 7.4% HIV prevalence
- Conclusion: Circumcised men are less likely to become infected with HIV

Scientists then designed studies to investigate further MC vs. HIV prevalence. They launched three studies where they recruited two groups of uncircumcised men. One group was later circumcised and both groups were followed over time. Scientists found that circumcised men were less like to become HIV infected. The studies also found other benefits, which we will discuss later today.

Why are MC Counsellors needed?

Counselling is a core component of MC service package

The minimum package of MC services includes: MC counselling, HIV testing and counselling, condom distribution, STI diagnosis and treatment and the procedure following national guidelines. As you can see, counsellors play a key role in most of the components that make up this package.

Counsellors are key to a successful MC intervention

- Help men understand benefits and risks of MC
- Help men plan for life after MC (risk reduction counselling and HIV testing)
- Respond to fears of men accessing MC
- Support men to make good decisions
- Ensure quality services

Research shows that men are interested in MC. Counsellors help them understand MC so that they can make informed decisions. Counsellors also help men think about and plan for the impact of MC on their lives. Counsellors make sure that men understand that MC is not 100% protection so they need to take measures to protect themselves after the procedure.

Facts about Male Circumcision

Male circumcision is the surgical removal of the foreskin from the head of a man or boy's penis.

Principal ***BENEFITS*** of male circumcision include:

1) Easier to keep penis clean
2) Reduced risk of some STIs, especially ulcerative diseases (chancroid and syphilis)
3) Reduced risk of HIV infection
4) Reduced risk of penile cancer
5) Reduced risk of cervical cancer for female sex partners
6) Reduced risk of urinary tract infections in children
7) Prevents phimosis and paraphimosis
8) Prevents balanoposthitis

Principal ***RISKS*** of male circumcision include:

1) Pain
2) Bleeding
3) Infection
4) Reaction to the anaesthesia
5) Swelling or bruises

Note: A circumcised man can still become infected with HIV and infect others. MC ***does not*** provide 100% protection from HIV.

Myths: There also exist many myths about MC (for example, that it increases or decreases sexual pleasure) but only the above benefits and risks are true. Counsellors should correct misinformation whenever they encounter it by providing only the facts related to MC.

Anatomy of the Penis

How the inner foreskin increases the risk of HIV acquisition:

1) HIV target cells are found in high concentration in the inner foreskin, and are close to the surface of the skin.
2) The surface of the inner foreskin can tear easily and bleed during sexual intercourse. These tears allow HIV to more easily enter the body.
3) Because it is moist, covered and soft, the foreskin is a perfect environment for organisms that cause most ulcerative STIs. These ulcerations in the foreskin allow HIV to more easily enter the body.

Flaccid uncircumcised penis

Erect uncircumcised penis

How does removing the foreskin reduce the risk of HIV acquisition?

By removing the foreskin:

1) The high concentrations of target cells found in the foreskin are also removed;
2) The head of the penis keratinizes (i.e. becomes thicker and harder) overtime, thereby making the skin of the penis less prone to tearing and injury; and,
3) The head of the penis is no longer covered to create a moist environment that helps ulcerative STIs to develop.

Although it is still possible to become infected with HIV, by removing the foreskin it becomes more difficult for HIV to enter the body through the penis.

Flaccid circumcised penis

Erect circumcised penis

The MC Procedure

Once the client has been counselled, tested for HIV and has provided consent (via legal guardian for minors), the following steps occur:

1. The client undergoes a clinical assessment to determine his eligibility for MC.
2. If the client is determined eligible for MC, he is escorted to the procedure area where he is prepared for the procedure.
3. In the procedure room, the client places himself on the procedure table.
4. The penis and skin around the groin area are cleaned using iodine and a drape is placed over the groin, exposing only the penis.
5. Local anaesthesia is injected into the base of the penis using a sterile needle.
6. After some minutes, the provider will confirm that the client does not feel pain before beginning the procedure.
7. The provider begins the procedure to remove the foreskin and suture the wound.
8. The provider applies bandages to the wound.
9. The client is escorted to the recovery room where he can relax and received post-procedure counselling and advice.
10. The client returns to the facility for follow-up assessments after two days, seven days and thirty days.

Post-procedure care for MC clients

To reduce the risk of problems following their procedure, **MC clients are advised to**:

1) Rest at home for one to two days; this will help you heal more quickly.
2) Take dry baths during the two days following your procedure, taking care not to get your bandages wet.
3) Do not pull or scratch your wound as it is healing.
4) Erections may cause some pain. Drinking lots of water and urinating can usually help reduce pain. Do not masturbate since this can damage the wound. Any pain from erections will go away after a few days.
5) Do not have sexual intercourse or masturbate for at least six weeks and be sure to always use a condom once you resume having sex.
6) Take any medications as directed by your MC provider.

MC clients are also advised to:

- Return to the facility for your two-day and seven-day post-procedure reviews. Your MC provider will remove your bandages and examine your wound to make sure it is healing properly.
- You may experience a little pain and swelling around the wound. This is normal but check occasionally to make sure it does not get worse.
- Return to the facility or call your MC provider if you have any of the following problems:
    - Bleeding that does not stop or gets worse
    - Severe pain
    - Inability to urinate
    - Pus coming out of wound
    - Increased swelling
    - A fever within one week of your procedure
    - Severe lower abdominal pain

Policy and Client Consent

Specific policies are implemented to ensure that MC is provided with full adherence to medical ethics and human rights principles, including informed consent, confidentiality, and absence of coercion.

(1) Informed consent is more than getting a client or parent/guardian to sign a written consent form. It is a discussion with your client that results in the client's authorization to undergo MC. In this discussion, you should explain the nature of MC, the risks and benefits, and what is required to maximize the benefits of MC (i.e. post-procedure care and protection). Your client should have an opportunity to ask questions so that he (or his parent/guardian) can make an informed decision to undergo or refuse MC. ***Non-consented MC cannot be justified in any circumstances.***

Who can provide consent for MC in Zambia?

- Children aged birth to 6 years—Parental/guardian consent
- Children aged 7 to 17 years—Parental/guardian consent and assent from client
- Men aged 18 years and above—client consent
- Children under 18 without parent or guardian—referred to appropriate resources at the Ministry of Community Development and Social Welfare.

(2) Confidentiality means that you will not share with others information revealed by your client or that you learn during the MC counselling process. By protecting the information disclosed during the counselling session your client will feel free to provide honest information that will help you understand better their situation and needs.

(3) Absence of coercion means that your client makes a decision to undergo MC based on his own free will, without pressure or coercion from you, his parents, or his sexual partners.

Counselling Protocol

Below is a counselling protocol that outlines the important topics to cover with each client. The sample questions and cues are presented as simple ways to introduce the topic and keep the conversation focused on your client.

Topic	Sample questions and cues	Key Messages
Introductions	*Good morning/Good afternoon, please take a seat.* *You are welcome... my name is _____ and I am a counsellor here at _____. Tell me something about yourself?* (Building rapport)	
Confidentiality	*I am happy you are here today and I would like to assure you that our discussion we will have today is confidential. What questions do you have about confidentiality?* (Open-ended questions)	
Gathering demographic information (Part 1- Client Information)	*Is it alright with you If I can ask you a few personal questions? This information is kept confidential and is used to know a little more about people coming through our services.* Collect demographic information for MC client in-take form.	
Assessing interest and address concerns	*What can I do for you today? What are some of the reasons you are interested in MC? What are some of your concerns about MC? (Open ended)* Immediately address concerns expressed by the client.	
Explaining the MC package	***Opening:*** *It is good that you have come for MC. MC is offered as a package so that you get the maximum benefits MC offers (Explain the MC package)* 'MC package includes .....) **Closing**: *What questions do you have about this process?*	MC package includes: • MC counselling • HIV testing • Safe sex and condom counselling • STI counselling and treatment
Benefits of MC	**Opening**: *What are some of the benefits you Know about male circumcision? What other benefits have you heard about male circumcision?* **Closing**: *Which of the benefits we have discussed is related to HIV?*	• Easier to keep penis clean • Reduced risk of some STIs, especially ulcerative diseases (chancroid and syphilis)

	Confirm that client understands the limitation of MC, with regards partial protection against HIV Infection after MC.	• Reduced risk of HIV infection • Reduced risk of penile cancer • Reduced risk of cervical cancer for female sex partners
Risk assessment	**Opening:** *What things are you doing now that might put you at risk of HIV infection? How often do you use condoms?*	
Personalized disease education	**Opening:** *Let me try to summarize what you have said… (*Summarize risks identified by client*)…does that sound about right?* Address each risk and explain in relation to client's risks to HIV infection.	
Routine HIV test (Provider-initiated HIV testing)	**Opening:** *As part of MC we carry out an HIV test. It's important to know your HIV status before undergoing MC. What are your thoughts about an HIV test? When was your last HIV test? What was the result?* If no prior HIV test in past 3 months, Obtain consent and conduct HIV test and continue with MC counselling until results develop. **Closing***: What concerns do you have about HIV testing?* Address concerns and offer key messages about testing.	• Partial protection from HIV is beneficial for persons who are not infected with HIV, it is therefore to have a test and know your HIV status. • HIV testing helps you plan for your future and make the best decisions. • For HIV + persons, HIV can complicate recovery after MC.
MC procedure	**Opening:** *While we wait for your HIV test results, we will continue to discuss more on male circumcision. What happens when you enter the procedure/surgical area for MC?* **Closing:** *What questions do you have about the procedure?*	• Injections is given at the base of penis for pain prevention—injections may be uncomfortable • Cut of foreskin and closing wound • Applies dressing to protect wound • Rest for about 15 minutes and receive counseling on recovery steps • Entire procedure takes less than 30 minutes
Risks and limitations of MC	**Opening**: *We have already talked about the benefits of circumcision but there are also some risks. What have you heard about the risks of circumcision? What do you know about the relationship between MC and HIV infection?*	• Pain during the recovery period • Bleeding • Blood clots under the skin

	Closing: *Which risks worry you most?* Address client's concerns.	• Infection • Reaction to the anesthesia • MC is not 100% protection from HIV—still need to practice safer sex
Recovery period	**Opening:** *What have you heard about the recovery period following circumcision?* **Closing:** *What things worry you about the six-week recovery period? What might you do to address these concerns?* Help the client to develop an action plan to address his concerns about the recovery period.	First 7 days— • Rest and keep the penis clean and dry • Wear clean underwear • Return to centre for scheduled reviews • Call or return to center or go to the nearest health center if you experience problems Recovery period— • Healing takes at least 6 weeks • No sex or masturbation for 6 weeks • Having sex too early can damage the wound and extend healing period • Sex too early is also risky for you and your partner • If you do have sex, be sure to always use a condom
Follow-up visits	**Opening:** *After your procedure, you will need to visit the centre at least two or more times. When do you think you should return to the clinic?* **Closing:** *How do you feel about these visits? What might prevent you from returning to the clinic? What can you do to make sure you come back to the clinic?*	• Bandages will be removed at the 2-day review • Health Provider will examine the wound to make sure you are healing properly • If you experience any problems, before or after your reviews, return to the center or visit the nearest health center • *Again after 7 days you need to return to the clinic and at 6 weeks*
HIV test results	Once HIV test results are developed, deliver results.	

	• If result is negative, continue with MC counselling. • If result is positive, refer to counselling protocol for HIV-positive clients.	
Life after MC	**Opening:** *How do you think your life will change after your MC procedure?* **Closing:** *It is important to know that some things will not change, like the need to protect yourself from HIV.*	• MC provides partial protection against HIV, you need to continue with safer sex
Goal setting	**Opening:** *What are some of the things you have done in the past to protect yourself from HIV? What else could you do?*	
Action planning	**Opening:** *What can you do to make this happen?* Support the client to develop a post-MC risk reduction plan.	
Wrap-up	*Thank you again for choosing our centre for your MC. If you think of any more questions, you are free to come back to the centre to see me or any other counsellor or during your clinical assessment and procedure.*	

Group Education vs. Individual Counselling

Group education is typically used to increase the number of clients that can be handled by one site. In group education, general information and topics are covered. Group education:

- Is used to support individual counselling services;
- Allows clients to receive basic information about MC before undergoing individual counselling;
- Can free time during the individual session to allow the counsellor to focus on specific issues related to male circumcision, or sexual and reproductive health, in general; and,
- Can shorten the time during individual counselling sessions, which is an advantage in busy clinics.

Techniques for Conducting Group Education Sessions

Some tips for conducting an effective group education session:

- Use the MC counselling tools to support group education;
- Encourage all clients to participate in the group education session;
- Introduce the topic clearly and state the objectives;
- Ask questions to find out what the group knows before providing all the information, there is no need to give information the group already knows;
- Consider the local cultural needs of the group and use appropriate topics and words that the group can understand;
- Use an interactive approach by asking questions and encouraging group members to ask questions; and,
- Praise group members when they participate.

Topics covered during group education would include:

- Explaining the MC package

- Benefits of MC
- MC procedure
- Risks and limitations of MC
- Recovery period
- Follow-up visits
- Life after MC

Even with group education, individual counselling is still necessary to complete client understanding of MC, provide HIV testing and counselling and support client's to develop individualised risk-reduction action plans for the post-MC period.

Review of the Client-Centred Counselling Approach

Client-centred counselling is an approach that places much of the responsibility for the counselling process on the client, with the counsellor taking a facilitative role. Client-centred counselling is the ideal approach because it:

1) Helps clients explore, express, understand and accept their own risk-taking behaviours
2) Is centred on a client's behaviours, circumstances and special needs
3) Includes a personalised risk assessment
4) Results in a personalized plan to reduce risk of HIV infection/transmission
5) Is supportive of the individual

Client-centred counselling is supported by the following techniques:

- Attending
- Open-ended questions
- Using simple language
- Using the third person
- Offering options

Attending

Attending is the different ways you use your physical presence to communicate to your client. Attending shows your client that you are listening and engaged. For effective attending, keep these important points in mind…

- Smiling
- Making eye contact
- Leaning toward my client (slightly)
- Keeping my arms open (not folding arms across my chest)
- Maintaining a calm voice
- Keeping my toes pointing in the direction of my client
- Not allowing furniture or paperwork to come between the counsellor and client

Open-ended questions

Open-ended questions are those that cannot be answered with “yes” and “no” or one word responses. Open-ended questions allow the client to elaborate and explain, providing you with more information. Open-ended questions start with: When, What, Where, Why, Who, and How. Examples:

- *How often do you use condoms?*
- *When is the last time you discussed HIV with your girlfriend?*
- *What are some of the reasons you’re interested in MC?*

Open-ended questions are supported by other techniques:

1) **Polite imperatives** such as, *Tell me about a time when you found it easy to use a condom.*
2) **Silence** to give the client time to think about his/her response.
3) **The Nth degree** such as, *What’s the worst fear you have about getting an HIV test?*

Using simple language

During sessions, counsellors should strive to use simple language, avoiding technical jargon and terms. Providing brief, simple explanations ensures the client’s comprehension.

Using the third person

Third personing is making statements that acknowledge and normalize feelings and concerns expressed by a client by referring to others in similar situations. Examples:

- *Many men I have spoken to also worry about pain during the procedure…*
- *Many of my clients say that it is easier to use a condom when your partner helps put it on.*

Convincing the Reluctant Man to Accept HIV Testing

HIV testing as an important component of the MC service package. Counsellors play an important role in helping clients to understand the benefits of knowing their HIV status prior to undergoing the procedure. HIV testing is offered to all MC clients using an opt-out approach, meaning that all clients will be tested for HIV unless they specifically decline the test.

Key messages related to HIV testing in the context of MC, include:

- HIV testing is a core component of the MC service package.
- To benefit fully from MC, clients need to know their HIV status
- HIV infection can complicate the recovery period, knowing helps the client plan for their recovery
- HIV testing helps the client plan for his future and make the best decisions

Counsellors play a key role in helping men to understand that to benefit fully from MC they need to undergo an HIV test.

Review of Risk Reduction Counselling

When counselling clients on MC, it is important to conduct a risk assessment and support the client to develop a risk reduction plan to stay safe after MC. Risk reduction counselling typically consists of the following steps:

1) Risk Assessment and Identification of Risk Triggers
2) Personalised disease education
3) Goal Setting
4) Action Planning (with offering options)

1) Risk assessment and identification of risk triggers

Risk assessments help clients identify behaviours that put them at risk of HIV infection. Risk triggers are those situations or habits that cause clients to do things that put them at risk of HIV infections. Examples: Having sex without a condom, having several girlfriends, etc.

2) Personalised Disease Education

Personalised disease education helps the client to understand how his current behaviours may put him at risk of HIV infection. Steps for personalised disease education include:

- **Summarise what the client has said during the risk assessment**. Example: "Joseph, let me summarise what you've already shared with me. You currently have two girlfriends and you never use condoms. You don't know the HIV status of either girlfriend and you're not sure if they are faithful to you. Did I get that right?"
- **Address each risk behaviour and link it to the possibility of HIV infection**. Example: "I need to tell you that having several sexual partners increases your risk of becoming HIV positive. Since you don't know the status of your partners and you're not sure if they are faithful to you, you are at high risk of HIV infection. Since you don't use condoms, you can easily be infected by either one of your partners if she is HIV positive and you can pass the infection on to your other partner."
- **Answer any questions your client has about HIV infection and their risk**.

3) Goal Setting

Goal setting helps the client establish specific goal/s that he can adopt to prevent or greatly reduce his risk of HIV infection. Examples: having only one sexual partner, using a condom, etc.

4) Action Planning

Action planning allows the client articulate steps that he will take to achieve his goal/s. Examples: carrying condoms, don't get drunk, etc. Action planning is supported by **offering options** since it allows the client to choose risk reductions strategies that are most relevant to their situation and needs.

Risk elimination behaviours are those that eliminate all possibility of becoming HIV-positive. The three most common strategies promoted through health education to prevent HIV infection are essentially ***risk elimination*** strategies: Abstinence, Be faithful and Condom use. HIV prevention messages are typically based on *risk elimination* but *risk reduction* messages are also viable options for many clients.

Other strategies exist that might *reduce* an individual's risk of HIV infection. These are called **risk reduction** behaviours as they reduce the likelihood of becoming HIV-positive. Risk reduction behaviours might include: getting tested for HIV, reducing your number of sexual partners, etc.

Instructions for Use of a Male Condom

A: Take the condom out of the packet

B: To put the condom on an erect penis before genital contact, expel air by pressing the teat of the condom with thumb and finger before putting on the condom on the tip of the penis.

C: With the other hand, unroll the condom to the base of the penis. The condom should unroll easily and need not be stretched. (If you are not circumcised, pull the fore skin back before you put the condom on the penis. With the other hand roll condom to the base of penis).

D: Take the penis out of the vagina soon after ejaculation. Do this while holding the condom against the penis to avoid it from slipping. Dispose of the condom appropriately.

Other instructions for use of a male condom:

- Be sure you have a condom every time you have sexual intercourse.
- Check for the expiry date.
- Check the condom packet for holes.
- Do not use petroleum-based products on the condom for lubrication. These products can cause rubber to tear. Use saliva, KY-jelly or other water-based lubricants.
- Do not reuse the condom. Store condoms away from heat.
- To help prevent the spread of infection, carefully dispose of the used condoms and their contents in one of the following ways:
    - burning them; or,
    - disposing them in a pit latrine or burying them in a deep pit.

Instructions for Use of a Female Condom

A: Squeeze the inner ring between thumb and finger

B: Find a comfortable position, and then insert the inner ring of the condom into the vagina

C: Place a finger inside the condom and push the inner ring up inside the vagina until it covers the cervix (neck of the womb)

D: Remove the finger after insertion. At intercourse, guide the penis through the outer ring into the condom placed in the vagina. Make sure the outer ring remains in place

Counselling Special Populations: Parents and Women

When counselling parents and women on MC, the following messages can be kept in mind while still maintaining a client-centred approach that responds to the needs and concerns of the client.

1. Key messages for **parents** about MC:
    - Discuss with your children the benefits and possible risks associated with MC
    - Support your children who want MC
    - Understand their role in signed consent
    - Monitor the healing process of the wound
    - Understand the long-term benefits of MC (especially for parents worried that MC might encourage their children to have sex)

2. Key messages for **women** (as sexual partners) about MC:
    - Go for couples HIV counselling and testing to benefit fully from MC
    - Talk about MC with your partner
    - Go with your partner to MC counselling
    - Support your partner during healing period
    - Continue to use condoms and limit number of sexual partners
    - Accompany your partner to the facility for the procedure
    - Women have a reduced risk of cervical cancer if their sexual partner is circumcised

Providing Referrals to other Services

Referrals are most effective when the counsellor does the following:

1) **Helps the client define priorities**—not all client needs can be met through one referral so it is good to help the client define his/her top priorities and focus on those.
2) **Discusses and brainstorms options**—clients need to know their options in terms of where and how they can access other services (public vs. private providers) and you should be prepared to discuss the advantages and disadvantages of each option.
3) **Sells the service then offers the referral**—counsellors need to help the client understand the importance of the referral.
4) **Refers to a known and trusted service**
5) **Facilitates an active referral**—counsellors should support clients to access the referral point by booking appointments, providing emotional support, etc.
6) **Develops a follow-up plan**—counsellors should plan to follow-up with clients to see how they have been able to access referral services and provide additional support, as needed.

By listening to our clients we can help them to identify opportunities to benefit from other health services.

Adult Learning Theory[7]

All trainers should understand the principles of adult learning. Participants in training sessions may come with a number of emotions, unresolved feelings, fears, and concerns that will influence their receptivity to the training content. They also may bring experiences, perspectives, and insights that will enrich the training. Thus, training is not just a matter of presenting new information to a passive, receptive audience. The trainer must carefully consider the emotional context in which this education takes place.

Malcolm Knowles, often referred to as the "father of adult education," found that adult learning occurs best when it follows certain principles. If trainers follow these guidelines, they will greatly enhance the learning experience for participants (Knowles, 1990). Arnold et al. (1991), among other adult educators, state that people retain:

- 20 percent of what they **hear**
- 30 percent of what they **see**
- 50 percent of what they **see** and **hear**
- 70 percent of what they **see, hear,** and **say** (e.g. discuss, explain to others)
- 90 percent of what they **see, hear, say**, and **do**

Therefore, for participants to retain what they learn in training workshops, they need a chance not only to **hear** a lecture or discussion, **see** a demonstration or visual aids, and discuss the material, but they must also have an opportunity to **do** something with the new information and skills. This can take the form of applying their new insights to a case study or role play exercise, or it can take the form of developing an action plan of ways to use their training insights in real life.

It is also important to remember the adult learning cycle. Participatory training is the hallmark of adult learning. It moves participants through the four phases of the adult learning cycle.

[7] Adapted from: National Cancer Institute, Trainer's Guide for Cancer Education, Bethesda, MD: National Cancer Institute; 2002 (pages 3-9).

The Adult Learning Cycle

It is important to move participants through this cycle at least once per module or 4-hour session. If your training will be more than 4 hours in length, it will be necessary to complete proportionately more full cycles.

Applying the Adult Learning Cycle to MC Counsellor Training: An Example

The MC counsellor training package was developed with the adult learning cycle in mind. Sessions are designed to be participatory and engage learners in a process of experiencing, processing, generalizing and applying new skills and knowledge. Here we provide a very brief overview of how the adult learning cycle has been applied in this training package.

Phase 1: Experiencing

The trainer might present a role-play wherein s/he conducts an MC counselling session. During this session, the trainer would model the correct use of key skills (i.e. open-ended questions, attending, risk reduction counselling, etc.) and tools (i.e. counselling cues cards). Through this modelling activity, the trainer is providing participants with a common "experience."

Phase 2: Processing

Next, the trainer would lead participants through a discussion of what they saw during the role-play. They would discuss what the trainer did and what problems they may have seen with the session. By processing the modelling activity, the trainer is helping the participants to understand the "mechanics" of MC counselling.

Phase 3: Generalizing

The trainer would continue the discussion but ask participants to compare how MC counselling compares to other types of counselling they have conducted. What lessons can be draw from those experiences and used to strengthen MC counselling.

Phase 4: Applying

Next, the trainer would give participants to practice MC counselling in small groups, drawing on the knowledge and skills they have developed and the role-play modelled by the facilitator. By applying the skills themselves, participants have an opportunity to practice and model the skills they have learned leading up to the role-plays.

Repeating the cycle

The trainer would then move to the next activity and the adult learning cycle would be repeated using the same structure of experiencing, processing, generalizing, and applying.

References

This training package (Facilitator Manual, Participant Workbook and Site Reference Manual) includes activities and sessions adapted from the following resources:

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