The bulk of provider communication, as expected, was a straightforward delivery of information on family planning and medical matters. Such information and questions about health and family planning accounted for about two-thirds of providers’ utterances (Table 3). One-fourth of providers’ communication was facilitative.

More than three-quarters of clients’ utterances came in direct response to the provider. Clients predominantly either answered providers’ questions about medical, family planning and routine matters (56%) or signaled agreement with or understanding of providers’ remarks (24%). Only about 10% of clients’ utterances were active; half of these were questions. This translates into clients’ asking an average of 1.6 questions per session.

Clients’ baseline ratings of their counseling experiences were skewed to the upper end of the five-point scale: 3.9 for self-expression, 4.0 for self-efficacy and 4.1 for satisfaction. These results are not surprising, given the strong social pressures in Indonesia against expressing disagreement. Thus, in this setting, even relatively small shifts in client assessments may be meaningful.

**Posttraining Communication Patterns**

The most dramatic impact of the training workshop observed in the month afterward was that the average length of counseling sessions almost doubled, to 11 minutes. Similarly, the total number of utterances by both provider and client jumped 86%, to 177. (Sessions grew shorter over the months that followed, but were still 40% longer at follow-up than they had been at baseline.)

Providers used most of the extra time to give clients additional information and counseling on medical and family planning issues. The number of utterances in this category rose from 27 to 58, and the proportion climbed from 39% to 48% (Table 3); both differences were highly statistically significant (p<.0001). Providers also asked more medical and family planning questions after training than before (18 vs. 16; p<.005), even though these questions accounted for a smaller proportion of their utterances. Since Indonesian providers generally give family planning clients limited information,13 the dramatic increase in information delivered represents an improvement in one aspect of counseling. However, the quality of information provided is also important, and the RIAS coding scheme does not permit us to assess the clarity, accuracy and relevance of information.

Training also had a positive impact on providers’ facilitative communication. Between baseline and the posttraining period, the average number of utterances in this category doubled from 15 to 30; as a proportion of providers’ contributions, they increased from 25% to 28% (p<.0001 for both increases). In percentage terms, providers increasingly acknowledged what clients said and offered information on lifestyle and psychosocial issues.

After training, clients’ active communication remained steady in percentage terms (Table 3) but more than doubled in frequency, from 3.3 to 7.0 utterances per session (p<.0001). Most of the increase was in acknowledging what the provider had said, as a consequence of the sharp rise in providers’ information-giving. However, the average number of questions per session also doubled (from 1.6 to 3.3; p<.0001), and that number held steady during the four-month follow-up period, even as consultations grew shorter.

All client ratings showed small increases after training. The self-expression rating rose to 4.1, self-efficacy to 4.1 and satisfaction to 4.2 (p<.0001 for each increase).

**Impact of Self-Assessment**

As Figure 1 shows, self-assessment alone had a significant impact on providers’ facilitative communication. The proportion of providers’ utterances that fell into this category increased from 28% to 33% in the group that conducted self-assessment only, while remaining essentially unchanged in the control group. A closer examination of the data (Table 4, page 8) shows two patterns at work. Some types of communication (partnership-building and asking questions) increased in the self-assessment group but stayed at the same level in the control group. Others (positive emotion and acknowledging clients’ remarks) declined significantly in the control group but not in the self-assessment group. Only the proportion of utterances devoted to personal or social conversation increased in both groups.

The level of clients’ active communication increased significantly in the self-assessment group but not in the control group (Table 5, page 9). The change was due to the substantial increase in clients’ social conversation in the self-assessment group and the decrease in their expressions of concern in the control group. Self-assessment also had a positive impact on other types of client communication (the provision of lifestyle, psychosocial, med-