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**Comprehensive  
Counseling for  
Reproductive Health:  
An Integrated  
Curriculum**

Participant's Handbook



**ENGENDERHEALTH**

*Improving Women's Health Worldwide*

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## Preface

Since the International Conference on Population and Development, held in Cairo in 1994, and the Fourth World Conference on Women, held in Beijing in 1995, the international development and public health communities have embraced a more comprehensive reproductive health agenda and have sought to provide an expanded range of services in a more integrated fashion. This shift to integrated reproductive health has included heightened attention to the rights of clients, the quality of care, informed choice, and gender sensitivity.

Equally important, the shift has brought increased recognition of clients' broad, interrelated sexual and reproductive health needs and of the changes required throughout the health care system to meet them. If service programs are to seize all opportunities to identify and meet clients' reproductive health needs more holistically, they must take a client-centered approach, link services so as to offer comprehensive care that covers clients' interrelated needs, and ensure that their providers are sensitive to medical, behavioral, and social issues that may underlie the expressed reasons for the client's visit.

Providers require training and institutional support to develop the skills, knowledge, and comfort they need to communicate effectively with their clients about health care that relates to the function of reproduction, the anatomy that supports that function, and the behaviors related to sexuality and reproduction. This includes, for example, family planning, maternal health, sexually transmitted infections, and related sexual practices. All of these services and subjects share certain characteristics that make them particularly sensitive: They are intensely personal and command a high degree of privacy; they are associated with strongly held beliefs; and they are the subject of social, religious, political, and legal strictures. All also are significantly affected by sexual partners and behaviors, which bear directly on an individual's choices, health status, and treatment outcomes.

In 2001, a literature survey conducted by EngenderHealth noted a dearth of training resources to help providers counsel clients about their reproductive health in a comprehensive manner. Existing training materials on counseling largely ignored a discussion of sexual practices and their relationship to health. Similarly, providers generally addressed the different areas of reproductive health care separately, without regard for what these areas have in common, for what linkages there are among them, or for how interrelated clients' reproductive health needs often are. Discomfort and lack of information related to sexuality as a health issue remain widespread among both clients and providers, posing a substantial barrier to effective client-oriented counseling and good client-provider interaction. Opportunities for addressing the whole client and all of his or her reproductive health needs too often are missed, producing a negative impact on the public health of communities.

This curriculum responds to the identified gap in existing training materials and fills a field-expressed need for help in developing knowledge about, skills in, attitudes toward, and comfort with effective communication and counseling in all areas of reproductive health, including sex-

## Preface

uality. It thus adopts the term *sexual and reproductive health* to describe the scope of health issues sought by those who would receive integrated counseling.

This curriculum's intended audiences are health care providers, their supervisors, and the managers of the programs in which they work. The counseling skills addressed here are expected to be relevant to the provision of both preventive and curative health services through the participants' national health systems. Finally, the curriculum's participatory approach to defining terms and to generating profiles of potential clients is designed to assist trainees in addressing the realities of and exploring the reproductive health priorities of their communities in a culturally appropriate manner.

# Acknowledgments

*Comprehensive Counseling for Reproductive Health: An Integrated Curriculum* represents the work of many teams and country programs at EngenderHealth. It is the culmination of a process that began in 1998, when sexual and reproductive health (SRH) counseling training tools and skills-development exercises were introduced to EngenderHealth<sup>1</sup> staff from five global teams and 12 country programs. This curriculum's development also involved follow-up surveys and interviews on field needs, a literature search and review of training materials, planning and coordination among several global teams, writing, and field testing. Thus, many individuals and EngenderHealth teams must be recognized and thanked for their input into this training package. (All individuals recognized below were with EngenderHealth when this curriculum was developed or written, unless otherwise noted; in addition, some EngenderHealth teams acknowledged here either no longer exist or operate under a different name.)

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- AVSC International. 1995. *Family planning counseling: A curriculum prototype*. Trainer's Manual. New York.
- EngenderHealth. 2000. *Introduction to men's reproductive health services*. Trainer's Manual and Participant's Handbook. New York.
- EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. Working draft. Volume 1—Manual; Volume 2—Handouts. New York.
- EngenderHealth. 2002. *Youth-friendly services: A manual for service providers*. New York.
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- EngenderHealth. 2003. *Counseling and communicating with men*. New York.
- EngenderHealth. 2003. *Counseling the postabortion client: A training curriculum*. New York.
- EngenderHealth. 2003. *Choices in family planning: Informed and voluntary decision making*. New York.

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## Part I

# Principles and Approaches for Client-Centered Communication in Sexual and Reproductive Health

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In this section, you will consider the context of sexual and reproductive health (SRH), identify typical SRH problems faced by people in their communities, and develop “client profiles” that will be used for case studies and role plays throughout the rest of the training. Since counseling focuses on facilitating decision making, the training sessions here explore the client’s decision-making process from the perspective of sexual and reproductive rights, informed and voluntary decision making, and the client’s rights in the service setting. Principles of client-provider interaction and counseling provide the foundation for developing key counseling skills, attitudes, and knowledge in the rest of the training.

# Session 1

## Welcome and Introduction

### Course Goal and Objectives

The goal of this workshop is to enable you to address clients' comprehensive sexual and reproductive health (SRH) needs by offering integrated SRH counseling services within your own particular service-delivery setting.

*Integrated sexual and reproductive health counseling* is defined as:

A two-way interaction between a client and a provider, to assess and address the client's overall SRH needs, knowledge, and concerns, regardless of what health service the provider is working within or what service the client has requested.

The general objectives of this curriculum are to ensure that, by the end of the training, you will have the knowledge, attitudes, and skills necessary to carry out the following key counseling tasks:

- Help clients assess their own needs for a range of SRH services, information, and emotional support
- Provide information appropriate to clients' identified problems and needs
- Assist clients in making their own voluntary and informed decisions
- Help clients develop the skills they will need to carry out those decisions

### Rationale: Why Integrated SRH Counseling?

Clients typically seek SRH services for *one* particular need or problem, and service providers typically respond to that *one* particular need or problem. However, people may have other needs or problems that contribute to their primary problem but that are never identified or addressed by a service provider. By not addressing those needs, providers may miss key opportunities to improve clients' overall health status. This problem of missed opportunities is particularly serious in SRH services, given the social stigma associated with many SRH problems, the embarrassment that many clients *and* providers feel about discussing these issues, and the potentially life-threatening consequences of high-risk pregnancies, sexually transmitted infections (STIs), and HIV and AIDS.

By helping you take a broader perspective and integrate clients' immediate needs or problems into their overall SRH status, this training can help you resolve issues contributing to clients' primary problems or prevent future SRH problems, as well as provide more comprehensive care. By focusing on the client as an individual and by considering factors both inside and outside the clinic setting that influence client decision making about SRH, you will be better able to assess and meet a client's informational, decision-making, and emotional needs. This will help the client make decisions that he or she is more likely to carry out and follow through more effectively with plans to seek treatment or change behavior.

## Participant Worksheet

### You Are the Client

Imagine that you are a married woman who would like to begin a method of family planning, and that you think you may have an infection that you got from your husband. You arrive at a clinic, only to be told that today is not the day for family planning counseling; today is antenatal and postpartum care day, and you are told that you will have to return tomorrow. You ask why they cannot talk with you today, and the response is that the providers already have too much work. You leave, not knowing whether you will be able to find transportation to come back again tomorrow, whether your husband will let you leave the house again, and whether you can come here again without anyone in your community seeing you.

Three weeks later, you have another opportunity to return to the clinic. This time you make sure it is on the family planning counseling day. While you are sitting with the provider discussing the family planning methods that are available, you mention that you may have a sexually transmitted infection (STI). The provider advises you to come back on Friday, when STI counseling takes place.

If you were this woman:

- Would you return to this clinic for STI counseling? Why or why not?
  
  
  
  
  
  
  
  
  
  
- What opportunities did the provider miss to help meet your needs?
  
  
  
  
  
  
  
  
  
  
- How could the provider have met your needs better?

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

## Session 2

# Defining Sexual and Reproductive Health and Integrated SRH Counseling

By the end of this session, you should be able to:

- Define the terms *sex*, *sexuality*, *reproductive health*, *sexual health*, and *sexual and reproductive health*
- Explain when and where integrated SRH *counseling* can be offered and how it relates to integrated SRH *services*
- Name at least four health and social services that are necessary to meet people's SRH needs and know where these services are provided in your community

### *Essential Ideas—Session 2*

- Sexual health and reproductive health are overlapping and intertwined concepts. Thus, the combined term *sexual and reproductive health* has emerged to include all aspects of health related to sexuality *and* reproduction.
- Integrated SRH counseling is a two-way interaction between a client and a provider intended to assess and address the client's overall SRH needs, knowledge, and concerns, regardless of what health service the provider is working within or what service the client has requested.
- Integrated SRH counseling is a critical component of integrated SRH services, in that it helps clients make best use of the range of services available. However, integrated SRH counseling can be offered in any service-delivery setting, with clients being referred for services not provided on-site. In addition, integrated SRH counseling can be an important component of outreach services, as a means of helping individuals identify their needs both for clinical care and for nonclinical strategies for changing their behavior.
- A common understanding of these terms helps providers better address clients' SRH needs and better communicate with colleagues about SRH.
- Although service providers may be limited in their work to the services that are offered at their service site, they should be aware of other services available in the community, so they can help clients access services not provided at that site.

## Session 2

### Definitions

#### **Sex**

*Sex* can mean the biological characteristics (anatomical, physiological, and genetic) that make us male or female.

*Sex* also can mean sexual activity, including sexual intercourse.

#### **Sexuality**

*Sexuality* is the way in which an individual *experiences* being male or female. This includes *physical* and *biological* aspects of one's life (e.g., menstruating, having wet dreams, being pregnant, or having sexual intercourse), as well as *emotional* aspects (such as being attracted to another person, including sexual orientation) and *social* aspects (such as behaving in ways that are expected by one's community, based on whether one is male or female; this includes gender roles).

Sexuality:

- Involves the mind and the body
- Is shaped by our values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, and ways in which we have been socialized
- Is influenced by social norms, culture, and religion
- Involves giving and receiving sexual pleasure, as well as enabling reproduction
- Spans our lifetimes

#### **Gender**

*Gender* is how an individual or society defines "female" or "male." *Gender roles* are socially and culturally defined attitudes, behaviors, expectations, and responsibilities for males and females. *Gender identity* is the personal, private conviction each of us has about being male or female; it defines the degree to which each person identifies himself or herself as male, female, or some combination of the two.

#### **Sexual Orientation**

*Heterosexuality* is an erotic or romantic attraction to people of the opposite sex. *Homosexuality* is an erotic or romantic attraction to people of the same sex. *Bisexuality* is an erotic or romantic attraction to people of both sexes.

#### **Reproductive Health**

According to a definition agreed to at the International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994:

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable meth-

ods of family planning of their choice ... and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems.

Source: UN, 1995.

### **Sexual Health**

The term *sexual health* includes aspects of sexuality not necessarily related to reproduction. It recognizes the fact that people may have sex for the purposes of pleasure, not just reproduction, and that people have health needs related to such sexual activity.

According to the International Women's Health Coalition (IWHC):

Sexual health means having a responsible, satisfying, and safe sex life. Achieving sexual health requires a positive approach to human sexuality and mutual respect between partners. By recognizing sexual health—and sexual rights—health and education systems can help prevent and treat the consequences of sexual violence, coercion, and discrimination, and can ensure that healthy human sexuality is enjoyed by all people and is accepted as part of their overall well-being.

The IWHC describes the basic elements of sexual health as:

- A sexual life free from disease, injury, violence, disability, unnecessary pain, or risk of death
- A sexual life free from fear, shame, guilt, and false beliefs about sexuality
- The capacity to enjoy and control one's own sexuality and reproduction

Source: IWHC, 2003.

### **Sexual and Reproductive Health**

Definitions of *sexual health* and *reproductive health* overlap. To avoid confusion and to ensure that all areas are covered, many providers, planners, and policy makers now use the term *sexual and reproductive health*, which includes everything included in both sexual health and reproductive health.

The term *sexual and reproductive health* can refer to a state of health and well-being, types of services, or an "approach" to service delivery, as follows:

#### **A state of health and well-being:**

- Physical, mental, and social well-being related to sexuality and reproduction
- Freedom to enjoy sexual relations without fear of pregnancy, disease, or abuse of power, sexual coercion, or violence
- Equal balance of power in sexual relations
- Respect for bodily integrity and the right to control one's own body

## Session 2

### **Types of services:**

- Pregnancy-related services (antenatal, postpartum, and emergency obstetric care)
- HIV and STI prevention and services
- Family planning
- Postabortion care
- Integrated services (e.g., family planning and HIV and STI prevention)

### **Approach to services:**

- The *way* in which services are provided
- The *issues* that are taken into account or addressed when services are provided
- New ways of providing *existing* services
- The *mentality* and *attitude* behind the way in which services are provided

Some examples of an “approach” to services include:

- Taking a holistic, integrated approach to reproductive health and to service provision
- Focusing on partner involvement and communication
- Promoting sensitivity to gender issues
- Promoting awareness of sexuality
- Taking into account the context of people’s decision making (e.g., gender power dynamics, poverty, domestic violence, and other vulnerabilities)
- Incorporating a human rights perspective in counseling and other services
- Fostering community involvement

### **Components of SRH Care**

According to the Programme of Action adopted at the ICPD in 1994 (Paragraphs 7.2, 7.3, and 7.6), the following are components of SRH care:

- Family planning information, counseling, and services
- Prevention and treatment of STIs and reproductive tract infections (RTIs)
- Diagnosis and treatment of HIV and AIDS
- Antenatal, postpartum, and delivery care
- Health care for infants
- Management of abortion-related complications
- Prevention and treatment of infertility
- Information, education, and counseling on human sexuality, SRH, and parenthood
- Diagnosis and treatment of cancers of the reproductive system

***Integrated SRH Counseling***

*Integrated SRH counseling* is a two-way interaction between a client and a provider, to assess and address the client's overall SRH needs, knowledge, and concerns, regardless of what health service they are working within or what service the client has requested.

In integrated SRH counseling, the provider's tasks or responsibilities are to:

- Help clients assess their own needs for a range of SRH services, information, and emotional support
- Provide information appropriate to clients' identified problems and needs
- Assist clients in making their own voluntary and informed decisions
- Help clients develop the skills necessary to carry out those decisions

***How Does Integrated SRH Counseling Relate to Integrated SRH Services?***

Integrated SRH counseling differs from integrated SRH services in several ways:

- The goal of integrated SRH services is to provide comprehensive health care services on-site and to promote linkages between these services. Integrated SRH counseling is a critical component of integrated SRH services that helps clients make best use of the range of services available.
- However, integrated SRH counseling can be offered in any service-delivery setting. Thus, a provider can discuss the full range of SRH issues about which the client may be concerned, regardless of the types of SRH services actually provided at that site. Meeting the client's needs may require referring him or her to services off-site or may require problem-solving to determine what the client can do about a situation for which services simply do not exist locally.
- Integrated SRH counseling can be provided anywhere and at any time. It does not even need to be directly linked with a clinic setting, because many prevention strategies (e.g., for preventing transmission of HIV or STIs) involve behavior change rather than clinical care. Thus, integrated SRH counseling can be a vital part of outreach services, as a means of helping individuals identify their needs both for clinical care and for nonclinical strategies for changing their behavior.

## Session 3

# Why Address Sexuality?

By the end of this session, you should be able to:

- Explain how the quality of integrated SRH counseling and services can be improved by including a focus on sexuality issues and concerns
- Describe barriers or challenges for providers in addressing sexuality in integrated SRH counseling
- Identify strategies for helping providers feel more comfortable about and be better equipped to address issues related to sexuality and sexual health

### *Essential Ideas—Session 3*

- Sexuality issues are directly related to informed choice and continuation in family planning services, and to the effectiveness of efforts to reduce the risk of HIV and STIs.
- Discussing sexuality may reveal underlying issues and concerns that affect clients' SRH-related needs and decisions.
- Discussing sexuality can improve the overall quality of care by fostering comfort and trust between clients and providers.
- Providers often shy away from discussions of sexuality because of their own discomfort or because they fear that such discussions may be culturally inappropriate or may offend clients.
- Providers *must* take the initiative by introducing sexuality-related issues in counseling.
- Providers can use many strategies to increase their comfort in discussing sexuality concerns with clients.

### **Key Discussion Points**

#### **1. Why is it important to address sexuality as a part of integrated SRH counseling?**

- Pregnancy and STIs are both outcomes of sexual activity.
- Reproductive health programs will have a limited impact if they do not consider the context in which people make decisions about their sexual lives and reproduction. Sexuality and sexual practices can have implications for a client's decisions about contraceptive

## Session 3

method use and HIV and STI risk reduction, as well as the client's ability to make decisions and to negotiate with his or her partner.

- Clients may have underlying concerns about sexuality that are the real reason for a clinic visit or that are more important than the stated reason.
- Providers who make assumptions about the sexual practices of their clients may provide inappropriate services. For example, they might promote family planning methods because they incorrectly assume that a client is having sex with people of the opposite sex. They may also assume that a woman only engages in vaginal sex and not anal sex, and therefore may fail to provide sufficient information about the risks of HIV and STIs. They might misdiagnose a vaginal infection as an RTI (i.e., an infection that was *not* transmitted sexually) when it is in fact an STI (i.e., one that *was* sexually transmitted).
- It is difficult to discuss STI prevention without discussing the specific sexual practices that place a person at risk, as well as the range of sexual practices that are safer.
- A client's needs may be related to sexual abuse or coercion, rape, or incest—issues that need to be addressed to provide effective services.
- People may stop using a contraceptive method if they perceive it to interfere with the sexual act or if it decreases sexual pleasure.
- Clients may feel reluctant to try a certain method (e.g., vasectomy or condoms) out of fear that it will affect sexual pleasure or response (for themselves, their partner, or both).
- Offering counseling about sexuality may help improve client satisfaction and help to attract new clients.

### **2. What barriers or challenges might providers experience in discussing sexuality issues with clients?**

- Providers may feel personally uncomfortable about discussing sexuality with anyone.
- Providers may feel that it is culturally inappropriate to discuss sexuality with clients.
- Providers may fear that clients will be offended if they are asked about their sex life.
- Providers may not know how to initiate a discussion about sexuality with clients.
- Providers may feel that there is not enough time to address sexuality issues in a counseling session.
- Providers may fear that clients will bring up topics or have questions that providers are unprepared to address.
- Clients may feel uncomfortable discussing sensitive subjects such as sexuality with providers.
- If the client and provider are of different sexes, or if there is a significant age difference, it may be awkward for them to talk about sexuality.

### **3. How can providers feel more comfortable and better equipped to address issues related to sexuality?**

- They can learn more about sexuality, to increase their comfort in talking about it.
- They can talk with other providers about their experiences in speaking with clients about sexuality.

- They can explain to the client the reason for discussing sexuality issues, by focusing on the importance of sexuality to the client's health and assuring the client that they are not asking out of their own curiosity.
- They can use language (i.e., terminology) that is comfortable for them and understandable to the client.
- If the provider is of the opposite sex of the client, they can ask another staff person of the same sex to be present during the discussion.
- Focus groups or interviews with community members or clients can be conducted to better inform providers about the sexuality concerns and service needs of the community.

## Session 4

# The Problem Tree— Roots and Consequences of SRH Problems

By the end of this session, you should be able to:

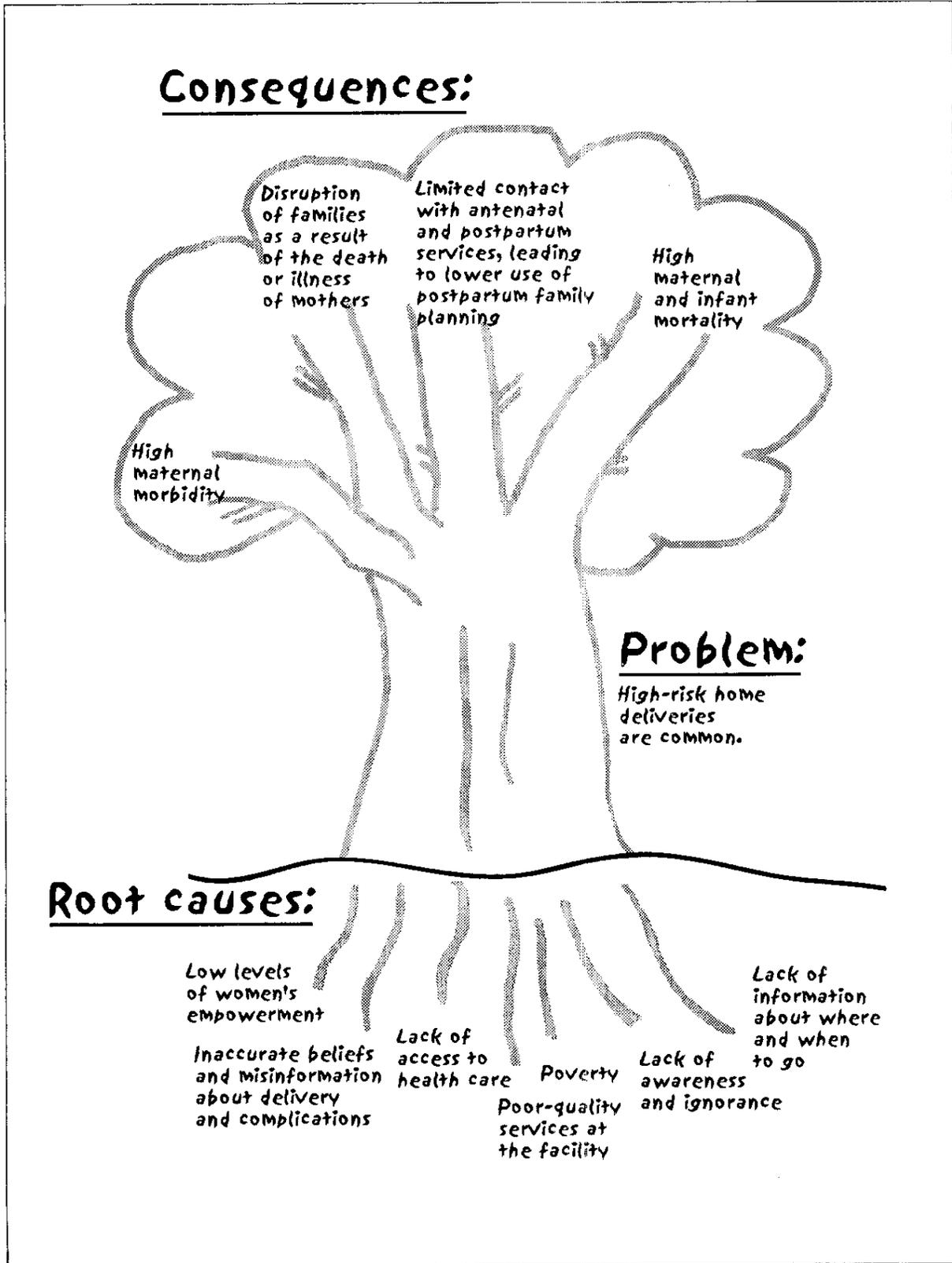
- Identify the causes and consequences of at least three SRH problems
- Describe the provider's role in addressing the causes and consequences of SRH problems

### *Essential Ideas—Session 4*

- The root causes of SRH problems are very complex, with as many social factors as medical ones, if not more.
- The consequences of SRH problems affect far more people than the clients seeking services—they affect their children, other partners, and sometimes the community. These consequences are also both social and medical.
- Multiple or multifaceted interventions are needed to address both the social and medical causes of these problems.
- Providers may think that they can only offer medical solutions, since their work is limited to the health care setting. However, through counseling, providers can educate clients about their rights and options and help empower clients to make changes in their lives. Providers can also use their role as health care professionals to reach out to communities and leaders, to educate them about the root causes of these problems and about the limitations and potential consequences of relying only on medical interventions.

*Note:* The content of this session is adapted from IIED, 2000.

Sample SRH Problem Tree: Maternal Health Care



## Session 5

# Supporting Clients' Informed and Voluntary Decision Making

By the end of this session, you should be able to:

- Explain the relationship between human rights and informed and voluntary decision making
- Name three sexual and reproductive rights recognized by international conventions
- Describe how sexual and reproductive rights apply to specific SRH needs and services in your country
- Define *informed and voluntary decision making*, and distinguish it from *informed consent*
- Identify at least one example of an informed and voluntary decision that a client can make in each SRH service area
- Describe three levels of factors that influence informed and voluntary decision making for SRH clients

### *Essential Ideas—Session 5*

- People's entitlement to make informed and voluntary decisions about their sexual and reproductive health is supported by several human rights that are recognized by the international community.
- Reproductive rights are recognized by international conventions signed by most countries of the world and include the right to decide on the number, spacing, and timing of children; the right to have the information and means to do so; the right to attain high standards of sexual and reproductive health; and the right to make these decisions without discrimination, coercion, or violence.
- Including women's "right to exercise control over their own sexuality" in our understanding of sexual and reproductive rights is an important breakthrough, since the right to decide about reproduction and the right "to attain the highest standard of sexual and reproductive health" have little meaning if women cannot decide if, when, and with whom they will have sex.
- Sexual and reproductive rights are only effective when people feel entitled to these rights and empowered to exercise them. Yet, everyday constraints—e.g., power imbalances between social groups, or between men and women—can pose barriers to the exercise of these rights.

*(continued)*

*Essential Ideas—Session 5 (continued)*

- Individuals and couples can make key decisions that significantly affect their health status in every area of SRH. The ability and means to make informed decisions in each of these areas is a fundamental expression of one's sexual and reproductive rights.
- At the same time, rights related to access to information and services—e.g., the right to information for unmarried people, the right of access to SRH services for adolescents, or the right to postabortion care without being forced to use a method of contraception—must exist for individuals to be able to make and act on their informed decisions.
- There are five basic elements necessary for informed and voluntary decision making:
  1. Service options are available.
  2. The decision-making process is voluntary.
  3. People have appropriate information.
  4. Good client-provider interaction, including counseling, is ensured.
  5. The social and rights context supports autonomous decision making.
- Each of these basic elements is influenced by factors that operate at three different levels: the level of the individual in the community context; governmental, legal, and SRH programming policies; and factors within the service-delivery setting itself.

**Informed and Voluntary Decision Making in Sexual and Reproductive Health**

The concept of *informed and voluntary decision making* applies broadly to any health care decision and assumes that individuals have both the right and the ability to make their own health care decisions. How does this concept relate to other similar concepts, such as informed consent and informed choice?

*Informed consent* is a medical, legal, and rights-based construct whereby the client agrees to receive medical treatment, to use a family planning method, or to take part in a study (ideally) as a result of the client's informed choice. Unfortunately, there are many instances in which a client signs an informed consent form without adequate information and without feeling that he or she has had any choice in the matter.

*Informed choice* is an individual's well-considered, voluntary decision based on options, information, and understanding.

This term originally was associated with family planning, wherein an individual freely chooses whether to use a contraceptive method and which one, based on his or her awareness of and

understanding of accurate information about the methods. Although informed choice could apply to any SRH service, some providers have difficulty understanding “informed choice” in non-family planning services, because there may be only one treatment option (e.g., only one medication for syphilis, and thus no “choice”) or the individual’s medical condition may require the provider to make emergency decisions for a client (e.g., in postabortion or emergency obstetric care).

We use the term *informed and voluntary decision making*, to underscore the importance of the decisions that individuals *do* make in every area of SRH, even when options are limited and their need is urgent. Examples of decisions that people make concerning their sexual and reproductive health include:

- *For STIs and HIV:* whether to use a condom with every act of sexual intercourse, whether to use a dual-protection strategy (to prevent both unintended pregnancy and STIs), whether to limit the number of sexual partners, whether to seek treatment for apparent infection, whether to inform partner(s) if an infection is diagnosed, whether to delay sexual intercourse until the infection is completely treated, and whether to be tested for HIV
- *For maternal health care:* whether to seek antenatal care during pregnancy, whether to improve one’s nutrition during pregnancy, whether and when to have sex during pregnancy, whether and when to go to a health care setting for assistance with delivery, whether to breastfeed exclusively and for how long, and whether to use contraception after delivery and when to start
- *For postabortion care:* what to do about an unintended pregnancy, whether and when to seek care following signs of spontaneous abortion, whether and when to seek care for complications of abortion (either spontaneous or induced), and whether to use contraception to prevent or delay future pregnancies
- *For family planning:* whether to use contraception to delay, space, or end childbearing, whether to continue using contraception when side effects occur, whether to switch methods when the current method is unsatisfactory, and whether to involve one’s partner(s) in decision making about family planning

The basic *elements* that support informed and voluntary SRH decision making are that:

- Service options are available.
- The decision-making process is voluntary.
- People have appropriate information.
- Good client-provider interaction, including counseling, is ensured.
- The social and rights context supports autonomous decision making.

*Source:* EngenderHealth, 2003a.

Decision making about SRH is complex and individualized and is often influenced by an interplay of factors related to individual circumstances—the social and rights contexts in which an individual lives; laws and policies affecting information and services; and practices in service delivery. Strategies to support clients’ rights to make informed and voluntary decisions about SRH need to consider all five basic elements and the factors influencing those elements at the community or individual level, the policy level, and the service-delivery level.

## Session 5

### *Community/individual*

Individuals' status (economic, education, gender, age, and marital) within their families and their culture influences their awareness of and ability to exercise their sexual and reproductive rights. Members of marginalized social groups, notably women and adolescents, are less able to assert their rights than are more privileged and powerful members of their community.

### *Service delivery*

Service providers should help give clients access to whatever SRH services they need and should support them in making the decisions necessary to achieve SRH. Service providers also need to understand sexual and reproductive rights, their role in supporting clients to exert these rights, and the power imbalances inherent both in their culture and in the client-provider relationship that can impede clients' ability to assert their rights.

### *Policy*

Policy factors affecting informed and voluntary decision making include laws, governmental goals, programming objectives, and service-delivery guidelines. Policies are meant to guide program managers, service providers, and clients themselves, in terms of the quality of care to be provided. However, the actual meaning and intent of many policies are not adequately communicated to the people who are to be guided by them.

**Participant Worksheet****Human Rights Supporting Informed  
and Voluntary Decision Making for Reproductive Health**

1. In your opinion, what are the three most important human rights related to reproductive health for people in your community or country?

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2. Why did you choose these three?

3. What challenges (if any) stop people from practicing these particular rights?

4. Why do people sometimes not practice their rights, even though they have them?

5. What could you do as a service provider to help people overcome barriers and practice their rights in support of their sexual and reproductive health?

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

## Session 6

# Client Profiles for Sexual and Reproductive Health Decision Making

By the end of this session, you should be able to:

- Develop “client profiles” that reflect each of the SRH-related topics to be addressed in this training and the variety of backgrounds, needs, and concerns that clients present
- Identify the decisions that your “clients” will need to make (based on their defined needs, concerns, and characteristics), the information that those clients will need if they are to make these decisions, and the emotional issues raised by their situations

### *Essential Ideas—Session 6*

- Clients have a wide range of needs and issues that they must deal with to get help for their SRH problems. Each person has a unique combination of background, socioeconomic and gender status, needs, concerns, and information. It is important to consider all of this when helping clients to make SRH-related decisions.
- There are few cases in which a client’s situation affects only himself or herself; someone else is almost always involved in the problem or is affected by whatever decision, if any, the client makes.
- Since we cannot possibly learn about every client’s needs, we will focus on a few profiles of “typical” clients throughout the remainder of this training and will see how what we learn affects each client’s thoughts, feelings, and decisions.

## Participant Worksheet

### SRH Decision Making

Imagine that you are a married 28-year-old man who is infected with HIV. While in the military, you were diagnosed after a mandatory test. The military dismissed you, but it was close enough to the end of your service that you were able to convince your family that you had finished your term of duty. You are married and have one 4-year-old daughter. Your wife is from a prominent family, and her father is angry that you and your wife have not yet had a son. You do not want anyone to know that you are HIV-positive, as you fear losing everything. You are sure that if your father-in-law finds out, he will find another man to marry your wife and he will take your daughter away from you. Also, your friends and others in the community are afraid of people with HIV. They fear that they will contract the virus easily from just being near anyone who has it. You know that you would lose your job, as you have heard of others losing their jobs due to being HIV-positive. You fear that the military will let everyone know sooner or later. You do not know how to handle this situation with your family, and you have come to an SRH clinic 35 miles from your home, hoping that no one will recognize you. You are looking for counseling to see if there is anything you can do medically to combat this virus.

If you were this man:

- What would be your current SRH needs?
  
- What decisions would you have to make? Who else would be involved in the decision making?
  
- What information would you need to make your decisions? Where could you get that information?
  
- Would you be comfortable seeking services for these SRH needs?
  
- How would you feel about your situation? What concerns or worries would you have?

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

## Session 7

# Clients' Rights, Client-Provider Interaction, and Counseling

By the end of this session, you should be able to:

- List at least four of the seven “rights of clients” and explain how they apply to SRH services
- Explain how different types of health care workers—frontline staff, providers, and administrators and supervisors—can be involved in supporting clients’ rights
- Define *client-provider interaction*
- Describe strategies to improve client-provider interaction and to support clients’ rights more effectively in the clinic setting
- Define *counseling*
- Explain how counseling supports clients’ rights
- Identify specific tasks that need to be carried out in counseling
- Explain how various types of staff in your work setting can carry out different counseling tasks

### *Essential Ideas—Session 7*

- The rights of the client are a subset of reproductive and sexual rights. They describe the essential aspects of service delivery to ensure quality of care, once a person has chosen to seek health care services.
- There are *many* people in the clinic setting who play a role in supporting clients’ rights—or in undermining them. It is important to consider the impact of *all* people with whom the client comes into contact in the clinic setting and determine how to make the best use of these “human resources.”
- *Client-provider interaction* refers to interpersonal communications (either verbal or nonverbal) between health care staff and the people who seek health care services. In this definition, “provider” includes everyone in the health care setting with whom the client interacts. This recognizes the importance of nonmedical staff to clients’ impressions of and messages that they associate with the health care setting.
- A client’s first impressions of a health care facility are usually made through interactions with frontline staff. The client’s sense of trust and confidence that

*(continued)*

*Essential Ideas—Session 7 (continued)*

he or she has made the right decision to seek SRH services can be reinforced or completely undermined by frontline staff.

- *Counseling* is a special type of client-provider interaction. It is two-way communication between a health care worker and a client, for the purpose of confirming or facilitating a decision by the client, or helping the client address problems or concerns.
- Counseling is the main safeguard for the client's right to informed choice. In addition, counseling can support each of the other clients' rights.
- Although clinical providers are usually responsible for the final stages of counseling, frontline staff can perform many preliminary steps, such as giving information about the client's options and gathering basic information about the client's condition.
- Utilizing frontline staff to cover initial phases of counseling, such as information-giving and information-gathering, allows providers to spend more time with the client on individual considerations and the actual decision-making process.

**The Rights of Clients**

**Information:** Clients have a right to accurate, appropriate, understandable, and unambiguous information related to reproductive health and sexuality, and to health overall. Educational materials for clients need to be available in all parts of the health care facility.

**Access to services:** Services must be affordable, available at times and places that are convenient to clients, without physical barriers to the health care facility, without inappropriate eligibility requirements for services, and without social barriers, including discrimination based on gender, age, marital status, fertility, nationality or ethnicity, social class, caste, or sexual orientation.

**Informed choice:** A voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding represents his or her informed choice. The process is a continuum that begins in the community, where people get information even before coming to a facility for services. It is the provider's responsibility either to confirm a client's informed choice or to help him or her reach one.

**Safety of services:** Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service-delivery guidelines, the existence of quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

**Privacy and confidentiality:** Clients have a right to privacy and confidentiality during delivery of services—for example, during counseling and physical examinations and in staff's handling of clients' medical records and other personal information.

**Dignity, comfort, and expression of opinion:** All clients have the right to be treated with respect and consideration. Providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when their views differ from those of service providers.

**Continuity of care:** All clients have a right to continuity of services and supplies, follow-up, and referral.

*Source:* AVSC International, 1999.

## Client-Provider Interaction

### **Definition**

Client-provider interaction is person-to-person communication (verbal and nonverbal) between clients and health care workers. ("Health care workers" can include anyone associated with a service site—e.g., medical and paramedical staff and outreach staff, as well as receptionists, cleaners, and drivers.)

Client-provider interaction occurs whether we pay attention to it or not—the client interacts with people from the moment he or she enters a service site. It is especially important to use good client-provider interaction with clients who are skeptical or distrustful of sexual and reproductive health services. Research has shown that clients are more satisfied and more likely to continue using services when they are treated with respect.

### **Purposes**

The purposes of positive client-provider interaction in SRH services are:

- To contribute to client satisfaction, to the effectiveness with which family planning methods or other regimens are used, and to continuation with family planning and other regimens or behaviors (e.g., continuously using oral contraceptives, or taking a complete course of medication for an STI or partner referral, among others)
- To help clients and SRH providers develop mutual respect, cooperation, and trust
- To help facilitate an appropriate free flow of information between and among SRH providers and clients, and to assist providers in assessing clients' needs and concerns
- To implement high standards regarding one of the six crucial quality-of-care elements: "interpersonal relations"

*Note:* Adapted from: INTRAH/PRIME, 1997.

## Session 7

### **Principles**

Key principles in client-provider interaction include the following:

- Treat each client well
- Tailor the interaction to the individual client's needs, circumstances, and concerns
- Interact; elicit the client's active participation
- Avoid information overload
- Provide the client's preferred method (for family planning) or address the client's primary concern (for other SRH issues)
- Use and provide memory aids

*Note:* Adapted from: USAID & WHO, 1997.

## **Counseling**

### **Definition and Tasks**

*Definition.* Counseling is two-way communication between a provider and client intended to create awareness of and to facilitate or confirm informed and voluntary SRH decision making by the client.

*Tasks.* When providing counseling, a health care worker is responsible for:

- Helping clients to assess their own needs for a range of SRH services, information, and emotional support
- Providing information appropriate to clients' identified problems and needs
- Assisting clients in making their own voluntary and informed decisions
- Helping clients develop the skills they will need to carry out those decisions

### **Essentials**

Few SRH programs can afford to pay staff whose only responsibility is to be a "counselor." In addition, few sites have private spaces designated only for counseling. Thus, *all* providers need to develop counseling skills and approaches to incorporate into *all* of their interactions with clients, including the following essentials:

- Compassion
- Common sense
- Communication skills
- Comprehensive, comprehensible information

### **Principles**

Since counseling is a form of client-provider interaction, the key principles for client-provider interaction also apply to counseling. In addition, the following can be considered key principles or behaviors of the provider:

- Create an atmosphere of privacy, respect, and trust
- Engage in two-way communication with the client

- Ensure confidentiality
- Remain nonjudgmental toward values, behaviors, and decisions that differ from your own
- Show empathy for the client's needs
- Demonstrate comfort in addressing sexual and gender issues
- Remain patient during the interaction with the client and express interest
- Provide reliable and factual information
- Support the client's sexual and reproductive rights

### Participant Worksheet

## Clients' Rights and Client-Provider Interaction

Potential client (teenage female) enters gate of clinic.

### *Negative interaction*

Guard (who is the girl's neighbor) is shocked to see her and gives her a mean look.

Receptionist asks the girl's age loudly and then shakes her head in disgust.

The girl, ashamed, hurries out of the clinic and vows to never return.

### *Positive interaction*

Guard (who is the girl's neighbor) does not say anything, as he does not want to embarrass her, but nods in greeting when she sees him.

Receptionist privately asks the girl a few questions and then reassures her that she has come to the right place and will be able to talk to a provider soon.

The young girl, now comfortable and somewhat relaxed, thinks about the questions she has for the provider.

Which of the client's rights were involved in these two interactions?

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

## Session 8

### Counseling Frameworks

#### Option A: REDI

By the end of this session, you should be able to:

- Describe REDI, a framework for integrated SRH counseling
- Identify which elements of this counseling framework you are already doing, which would require more training, and which would encounter challenges at your work sites
- Explain the importance of applying counseling frameworks to each client's unique situation
- Explain the importance of addressing the social context for decision making in integrated SRH counseling
- Describe how integrated SRH counseling supports informed and voluntary decision making by clients
- [If you are already familiar with GATHER.] identify similarities and differences between REDI and GATHER

#### *Essential Ideas—Session 8: Option A*

- The REDI framework (which stands for Rapport-building, Exploration, Decision-making, and Implementing the decision) is suitable for integrated SRH counseling in the following ways: It emphasizes the client's responsibility for making a decision and for carrying it out; it provides guidelines for considering the client's sexual relationships and social context; and it addresses the challenges that a client may face in carrying out this decision and offers skills-development to help clients meet these challenges.
- The most important thing to remember about counseling models is that the client is more important than the framework. Frameworks can be helpful to providers in giving you a structure for talking with the client, so that you do not miss important steps. Too often, though, the provider may focus more on following the steps than on responding to what the client is saying. The bottom line in counseling is to first figure out what the client needs and then how to help him or her meet those needs.
- Whatever framework is used for counseling, it is important to personalize counseling sessions by exploring each client's individual situation, as opposed to talking generally about family planning methods or HIV and STI transmission and prevention. By personalizing the discussion and applying it to the client's specific situation, you can help clients to perceive their own risks, rather than think of unintended pregnancy or AIDS as "things that happen to other people."

*(continued)*

*Essential Ideas—Session 8A (continued)*

- During client-centered counseling, avoid overloading clients with unnecessary information. To do this, you should first examine the client’s situation and then tailor the session to meet his or her needs.
- Understanding and exploring the social context of decisions is critical to helping clients determine their risk and make realistic decisions about pregnancy, HIV and STI prevention, and safe motherhood. This context includes a client’s power to make decisions about reproduction and sexuality and the people and factors that influence a person’s decisions, such as partners, family members, or friends. This also includes anticipating the outcomes of decisions, such as whether a decision (like suggesting condom use with a husband) could lead to violence.
- With integrated SRH counseling, voluntary and informed decision making is based on the client’s understanding and perceiving his or her own situation and risks, and having enough knowledge about options and their consequences to make decisions. It also involves considering the social and personal context for decision making by the client, supporting clients’ rights to access information and services and helping the client to figure out a way to make his or her own decisions within that context.
- REDI provides a useful framework, but this does not mean that it must be followed exactly or in sequential order during a counseling session. REDI is merely a suggested guide of steps and topics to cover while the provider and client engage in an interactive two-way discussion of the client’s needs and risks.

**REDI (Short Version)**

**Phase 1: Rapport-building**

- Welcome the client
- Make introductions
- Introduce the subject of sexuality
- Assure confidentiality

**Phase 2: Exploration**

- Explore the client’s needs, risks, sexual life, social context, and circumstances
- Assess the client’s knowledge and give information, as needed
- Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk

**Phase 3: Decision making**

- Identify what decisions the client needs to make in this session
- Identify the client’s options for each decision
- Weigh the benefits, disadvantages, and consequences of each option
- Assist the client to make his or her own realistic decisions

**Phase 4: Implementing the decision**

- Make a concrete, specific plan for carrying out the decision
- Identify skills that the client will need to carry out the decision
- Practice skills, as needed, with the provider’s help
- Make a plan for follow-up

*Note:* Adapted from: EngenderHealth, 2002; Pyakuryal, Bhatta, & Frey, no date; and Gordon & Gordon, 1992.

## **REDI: Rapport-Building, Exploration, Decision Making, and Implementing the Decision**

*Note:* The bullets below are suggestions for areas to address in each phase of REDI. They are not meant as a checklist to follow in strict order, nor are they to be read or recited to the client. The interaction should always be tailored to the client's situation.

### ***Phase 1: Rapport-Building***

1. Welcome the client
  - Greet the client warmly
  - Help the client to feel comfortable and relaxed
2. Make introductions
  - Identify the reason for the client's visit
  - Ask general questions, such as name, age, number of children, etc.
3. Introduce the subject of sexuality
  - Explain the reasons for asking questions about sexuality
  - Put it in the context of HIV and STIs, and assure the client that you discuss HIV and STIs with all clients
  - Explain that the client does not have to answer all of your questions
4. Assure confidentiality
  - Explain the purpose of and the policy on confidentiality
  - Create an atmosphere of privacy by ensuring that no one can overhear your conversation, even if you are not able to use a separate room

### ***Phase 2: Exploration***

1. Explore the client's needs, risks, sexual life, social context, and circumstances
  - Assess what the client understands about his or her SRH condition or situation, what worries or concerns he or she might have, and what he or she specifically hopes to accomplish through the visit
  - Explore the context of the client's sexual relationships:
    - ▶ What sexual relationships is he or she in, what is the nature of the relationships (including any violence or abuse), and how does he or she feel about it?
    - ▶ How does he or she communicate with partners about sexuality, family planning, and HIV and STIs?
    - ▶ What does he or she know about his or her partners' sexual behavior outside of the relationship?
  - Explore the client's pregnancy history and knowledge of and use of family planning methods, including condoms
  - Explore the client's HIV and STI history, present symptoms, and knowledge of partners' HIV and STI history

## Session 8A

- Explore other factors about the client's circumstances that may limit his or her power or control over decision making, such as financial dependence on partners, tensions within an extended family, and fear of violence, among others
2. Assess the client's knowledge and give information, as needed
    - Assess the client's knowledge of pregnancy-related care (if appropriate), postabortion care (if appropriate), family planning, HIV, and STIs
    - Correct misinformation and fill in gaps, as needed
  3. Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk
    - Ask the client if he or she feels at risk for unintended pregnancy or for HIV and STI transmission, and explore why or why not
    - Ask the client if he or she thinks that his or her partners may be at risk for unintended pregnancy or HIV and STI transmission, and explore the reasons
    - Explain HIV and STI transmission and pregnancy risks (as necessary), relating them to the individual sexual practices of the client and his or her partners
    - Help the client to recognize and acknowledge his or her risks for HIV and STI transmission or unintended pregnancy

### ***Phase 3: Decision Making***

1. Identify what decisions the client needs to make in this session
  - Help the client to prioritize the decisions, to determine which are the most important to address today
  - Explain the importance of the client's making his or her own decisions
2. Identify the client's options for each decision
  - Many providers and clients feel that in most areas of SRH, the client's decision-making options are limited. An important role of the provider is to lay out the various decisions that a client could make, to explore the consequences of each. This empowers the client to make his or her own choice, which is a key element of supporting the client's sexual and reproductive rights.
3. Weigh the benefits, disadvantages, and consequences of each option
  - Make sure the discussion centers on options that meet the clients' individual needs, taking into account their preferences and concerns
  - Provide more detailed information, as necessary, on the options that the client is considering
  - Consider who else would be affected by each decision
  - Explore with the client how he or she thinks that partners or family members may react to the course of action (i.e., suggesting condom use or discussing sexuality with partners)
4. Assist the client to make his or her own realistic decisions
  - Ask the client what is his or her decision (i.e., what option he or she chooses)
  - Have the client explain in his or her own words why he or she is making this decision
  - Check to see that this decision is the choice of the client, free of pressure from spouse, partner, family members, friends, or service providers
  - Help the client to assess whether his or her decision can actually be carried out, given his or her relationships, family life, and economic situation, among other issues

**Phase 4: Implementing the Decision**

1. Make a concrete, specific plan for carrying out the decision
  - Be *specific*. If a client says that he or she is going to do something, find out when, under what circumstances, and what his or her next steps will be in each situation. Asking a client “What will you do next?” is important in developing a plan to reduce risk. For example, if a client says that he will start to use condoms, the provider should ask, “How often?” “Where will you get the condoms?” “How will you pay for them?” “How will you tell your partner that you want to use them?” and “Where will you keep them so you will have them with you when you need them?”
  - Ask about possible consequences of the plan: “How will your partner(s) react?” “Do you fear any negative consequences?” “How will the plan affect relationships with your partners?” “Can you communicate *directly* about the plan with your partners?” and “Will indirect communication be more effective at first?”
  - Ask about social supports. Who in the client’s life can help the client carry out the plan? Who might create obstacles? How will the client deal with a lack of support or with individuals who interfere with the client’s efforts to reduce risk?
  - Make a “Plan B”—that is, if the plan does not work, then what can the client do?
2. Identify skills that the client will need to carry out the decision (see number 3, below)
3. Practice skills, as needed, with the provider’s help
  - Partner communication and negotiation skills
    - Discuss the client’s fears or concerns about communicating and negotiating with partners about condom use, family planning, maternal health concerns, safer sex, or sexuality, and offer ideas for improving communication and negotiation
    - For a client who feels that it may be difficult to negotiate condom use for HIV and STI prevention, discuss whether it might be easier to introduce condoms for pregnancy prevention
    - Role-play with the client possible communication and negotiation situations
  - Condom-use skills
    - Demonstrate correct condom use on a penis model, describe the steps, and ask the client to repeat the demonstration to be sure that he or she understands
    - Discuss strategies for making condom use more acceptable to partners
    - Provide samples of condoms (if possible) and make sure that the client knows where and how to obtain more
  - Skills in using other family planning methods
    - Make sure that the client understands how to use other family planning methods that he or she has selected by asking the client to repeat back basic information and by encouraging him or her to ask for clarification
4. Make a plan for follow-up
  - Invite the client to return for a follow-up visit to provide ongoing support with decision making, negotiation, and behavior change
  - Explain timing for medical follow-up visit or contraceptive resupply
  - Make referral for services not provided at your facility

## Discussion Summary

### 1. How does this framework ensure that the counseling is client-centered?

- The framework starts with the client's situation and takes into account the client's individual circumstances. Each counseling session can then be tailored to the client's needs.

### 2. How much time do providers in your facility generally spend counseling each client? Do you think this framework helps providers to work within this time frame? Do you think providers can save time with this framework? If yes, how? If no, why not?

- Providers can ultimately save time by learning first about the client's situation and then limiting the information-giving portion of the session to addressing what the client truly needs to know, rather than providing detailed information on every option.
- At first, it might take longer for providers to follow the framework because they may need to adjust to the new way of interacting with clients.

### 3. Why does the framework address the “social context” of clients' decisions?

- It is important to address the “social context” of decisions, to help clients identify and address potential barriers or obstacles to carrying out their decisions. This might include:
  - Who has the decision-making power in the relationship and who influences decisions (e.g., partners, friends, or family members)
  - Economic pressures that may affect decisions (e.g., who will pay for contraceptive supplies or treatment for STIs)
  - Possible negative reactions of partner(s) or family members
- Clients need to make realistic decisions that they can carry out successfully and safely. Examining the social context helps them understand the potential consequences of their decisions (e.g., a partner's potentially violent reaction if a client insists on condom use).

### 4. How does this framework ensure a client's informed and voluntary decision making?

- The framework focuses on helping clients make their own informed decisions and develop skills to carry out these decisions, rather than on steering the client to a particular decision.
- The framework helps clients understand and perceive their own risks for unintended pregnancy and HIV or STI transmission and provides them with knowledge about the various options to protect themselves, allowing them to make informed decisions.

## Session 8

### Counseling Frameworks

#### Option B: GATHER

*Note:* This exercise is designed for providers who already use the GATHER model for family planning, if they choose to continue using this model. If not, they can use the REDI framework.

By the end of this session, you should be able to:

- Incorporate sexuality, HIV and STI prevention, postabortion care, and maternal health care into the GATHER counseling framework
- Explain the importance of applying counseling frameworks to each client's unique situation
- Explain the importance of addressing the social context for decision making in integrated SRH counseling
- Describe how integrated SRH counseling supports informed and voluntary decision making by clients

#### *Essential Ideas—Session 8: Option B*

- The GATHER approach can be an important tool to ensure that providers are client-focused, since it emphasizes learning about the client and having a dialogue together, rather than talking *at* the client. Ensuring informed choice is a critical element of GATHER.
- Revising GATHER to address HIV and STI prevention, sexuality, maternal health care, postabortion care, and family planning involves thinking about the whole client. Specifically, this involves exploring the following: the client's circumstances, the nature of his or her sexual relationships, how he or she perceives risks (of pregnancy, HIV and STIs, pregnancy complications, or sexual violence, among others), and how the provider can help the client to protect himself or herself and lead a healthy, satisfying sexual and reproductive life.
- The most important thing to remember about counseling models is that the client is more important than the framework. Frameworks can be helpful to providers in giving you a structure for talking with the client, so that you do not miss important steps. Too often, though, the provider may focus more on following the steps than on responding to what the client is saying. The bottom line in counseling is to figure out first what the client needs and then how to help him or her meet those needs.

*(continued)*

*Essential Ideas—Session 8B (continued)*

- Whatever framework is used for counseling, it is important to personalize counseling sessions by exploring each client's individual situation, as opposed to talking generally about family planning methods or about HIV and STI transmission and prevention. By personalizing the information about pregnancy and HIV and STI risks and applying it to the client's specific situation, you can help clients to perceive their own risks, rather than think of unintended pregnancy or AIDS as "things that happen to other people."
- During client-centered counseling, avoid overloading clients with unnecessary information. To do this, you should first examine the client's situation and then tailor the session to meet his or her needs.
- GATHER provides a useful framework, but this does not mean that it must be followed exactly or in sequential order during a counseling session. GATHER is merely a suggested guide of steps and topics to cover while the provider and client engage in an interactive two-way discussion of the client's needs and risks.
- Understanding and exploring the social context of decisions is critical to helping clients determine their risk and make realistic decisions about pregnancy, HIV and STI prevention, and safe motherhood. This context includes a client's power to make decisions about reproduction and sexuality and the people and factors that influence a person's decisions, including partners, family members, and friends. This also includes anticipating the outcomes of decisions, such as whether a decision (like suggesting condom use with a husband) could lead to violence.
- With integrated SRH counseling, voluntary and informed decision making is based on the client's understanding and perceiving his or her own situation and risks, and knowing enough about options and their consequences to make decisions. It also involves considering the social and personal context for decision making by the client, supporting clients' rights to access information and services, and helping the client figure out a way to make his or her own decisions within that context.

## The Dual-Protection GATHER Approach

*Note:* The Dual-Protection GATHER Approach is one example of how other SRH concerns besides family planning can be woven into GATHER. In this case, the additional issues are sexuality and prevention of HIV and STIs. (Using strategies to prevent pregnancy and STIs at the same time is called “dual protection.”) In your training, you will also consider how to integrate maternal health care and postabortion care into the GATHER framework.

**G = GREET** the client politely and warmly. This includes praising the client for coming in and explaining that the discussion is confidential, including the facility’s confidentiality policy, if applicable. These are both important parts of building “rapport” with a client—developing feelings of safety and trust so that clients will feel comfortable talking with you about their SRH concerns, particularly issues related to HIV and STIs, sexuality, and dual protection (for HIV or STIs and for pregnancy).

**A = ASK** the client about himself or herself, his or her family members, and his or her general life circumstances. Ask the client why he or she has come to the facility. As the client gives you information about why he or she has come in, ask probing questions as part of the assessment process. (Make the client aware that you ask these questions of all clients, to best serve his or her SRH needs.) Ask about the client’s current sexual life (and behaviors) and sexual history, what he or she knows about his or her partner’s sexual behaviors, about HIV and STIs, about family planning, and about condoms, if he or she perceives himself or herself to be at risk of infection with HIV and STIs, unintended pregnancy, or violence, or if he or she has other sexual health concerns.

**T = TELL** the client about what kinds of services the facility offers, options for family planning and dual protection, basic information about each family planning method (including how well they prevent HIV and STIs as well as pregnancy, and how they may impact sexuality), and ways of preventing HIV and STIs, with an emphasis on condom use. The amount and extent of the information will have to be determined by the provider on a case-by-case basis. Apply information about HIV and STI transmission and risk as well as pregnancy to the client’s individual situation and needs to help him or her perceive any risks.

**H = HELP** the client make the decision that is best for him or her, including developing a plan for reducing risk of HIV and STIs or unintended pregnancy. This does not mean making the decision *for* the client; it means helping the client determine if he or she is at risk for HIV and STIs or unintended pregnancy and helping the client decide what he or she will do to reduce these risks. This may involve helping the client select a family planning method, keeping in mind potential HIV and STI risk and the impact of the method on sexuality. It also may involve working with the client to anticipate partner reaction to introducing condoms or discussing sexuality or STI risk behaviors, including a negative reaction or violence. It may involve weighing the costs and benefits of introducing condoms. If male condom use is not feasible, it may include discussing other strategies (such as using female condoms or having the partner come for counseling).

## Session 8B

**E** = EXPLAIN whatever needs explanation or clarification: how the facility works, how a family planning method works, how a method may affect sexuality, how condoms are effective for dual protection, how STIs can be prevented, how any medication needs to be taken, or about abstaining from sexual behaviors until an infection has cleared up. Demonstrate how to use a condom using a penis model and have the client practice this. Explore how the client will follow through on a plan to reduce risk for HIV and STIs or unintended pregnancy. Explore how the client will confront and address obstacles. If applicable, role-play ways to negotiate condom use or to introduce discussions about sexuality, condom use, or STI risk reduction.

**R** = Schedule a RETURN visit. Whenever possible, schedule follow-up appointments with clients to assess their ongoing progress in carrying out their plan for reducing risk and to make changes in the plan, if necessary. Provide additional information, resources, or referrals, as needed (for voluntary counseling and testing, HIV care and support, STI screening, or STI treatment, among others).

*Note:* Adapted from: EngenderHealth, 2002.

## Part II

# The Role of Providers' Attitudes in Creating a Good Climate for Communication

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The provider's attitude toward the client is a key factor in effective counseling. Yet many providers are personally challenged by the necessity to discuss SRH needs, beliefs, and behaviors that may differ from their own, or may have difficulties in addressing these issues with particular types of clients (e.g., unmarried women, adolescents, or men). These training sessions set the stage for discussions about providers' attitudes, values, and beliefs and their impact on clients—discussions that will be reinforced throughout the training during group work, discussions, and role plays.

## Session 9 Rapport-Building— Respect, Praise, and Encouragement

By the end of this session, you should be able to:

- Name the four steps of the “rapport-building” phase of REDI (or the main purpose of the “greet” step in GATHER)
- Explain the importance of showing respect for clients
- Describe at least two ways in which providers can show respect for clients
- Explain how praise and encouragement can help to build rapport between providers and clients

### *Essential Ideas—Session 9*

- The four steps of “rapport-building” are:
  - Welcome the client
  - Make introductions
  - Introduce the subject of sexuality
  - Assure confidentiality
- Aspects of welcoming the client include being friendly, nonjudgmental, and respectful, and showing interest in the client’s situation and needs.
- Different cultures have different customs for showing respect between individuals. It is important for providers to consider how they show respect for their clients. They should also consider the power imbalances that may exist between themselves and clients, due to socioeconomic status or education, and how such imbalances may affect communications between providers and clients.
- Praise and encouragement can be useful in establishing rapport with clients. Genuine praise and encouragement for clients will show respect for their efforts as individuals to try to deal with health problems, no matter how misguided or uninformed their efforts may be.

## Session 9

### Praise and Encouragement

Showing respect supports clients' right to dignity in their interactions with providers. In many cultures, *genuine* praise and encouragement for clients will show respect for their efforts as individuals to try to deal with health problems, no matter how misguided or uninformed their past efforts may have been. In addition, praise and encouragement are usually effective in helping clients to acknowledge and solve their problems.

#### **Praise**

Praise means the expression of approval or admiration. In the health care setting, to give praise means reinforcing good behavior—i.e., identifying and supporting the good things clients have done. Examples include:

- Showing that you respect their concern for their health
- Acknowledging difficulties they may have overcome to be at the facility
- Looking for something to approve of rather than to criticize

#### **Encouragement**

Encouragement means giving courage, confidence, and hope. In the health care setting, to give encouragement means letting clients know that you believe they can overcome their problems and helping them find ways to do so. Examples include:

- Pointing out hopeful possibilities
- Focusing on what is good about what they have done and urging them to continue
- Telling them they are already helping themselves by coming to the health facility

*Note:* Adapted from: Tabbutt, 1995.

### Praise and Encouragement: Client Situations and Provider Responses

Client's situation and statement	Provider's response
Woman whose first antenatal visit is in the ninth month of pregnancy: "I wanted to come for antenatal care before now, but I could not find anyone to look after my other children."	"I know that can be hard. It is good that you made the effort to come now."
Woman who arrives at the hospital in difficult labor: "I hope you can help me—my mother-in-law did not think it was necessary for me to come."	"It must have been difficult for you to decide to come to the hospital. It is good that you came now. Let us see what we can do to help you."
Parent of an adolescent: "My teenage daughter has been sleeping with her boyfriend because of pills she got from this health center!"	"I can understand your concern, and I am glad you came to discuss this."
Husband comes with wife, who has a vaginal discharge: "My wife tells me I should come, but this is her problem, not mine."	"I know it may not seem necessary to you, but it is good that you came anyway. It shows that you care about your wife's health."

## Participant Worksheet

### Contract of Respect

As a provider, you have probably found skills that help you to talk to diverse people about various problems. However, have you thought about how you do this and how you can do it better? An essential aspect of establishing rapport and building trust is to show respect.

Answer the following questions. Your responses will constitute a “contract of respect.” This contract will highlight your promise of respect for your clients.

- How do you demonstrate respect for clients and their decisions?
- How do you establish rapport with clients?
- How do you assure clients that discussions are confidential?
- How do you maintain a trusting relationship with clients?
- How do you support clients’ right and ability to make decisions?
- How do you respond respectfully to clients whose values or decisions you do not agree with?

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

## Session 10

### Provider Beliefs and Attitudes

By the end of this session, you should be able to:

- Explain how providers' beliefs and attitudes can affect their interactions with clients, both positively and negatively
- Explain the importance of being aware of your own beliefs and attitudes, to avoid imposing them on clients or having them become barriers to communication

#### *Essential Ideas—Session 10*

- Our *beliefs* shape our *attitudes*, or the way that we think about and act toward particular people and ideas. However, our beliefs and attitudes are often so ingrained that we may be unaware of them until we are confronted with a situation that challenges them.
- Everyone has a right to his or her own beliefs. However, health care providers have a professional obligation to provide health care and to do so in a respectful and nonjudgmental manner. Being aware of your personal beliefs and how they affect others—both positively and negatively—will help you do just that.
- How we communicate our beliefs and attitudes (both verbally and nonverbally) is an important aspect of our interactions with clients. Every interaction between health care staff and a client, from the moment he or she enters the health care setting until he or she leaves, affects the client by having an impact on his or her:
  - Willingness to trust and to share personal information and concerns
  - Ability to listen and to retain important information
  - Capacity to make decisions that accurately reflect his or her situation, needs, and concerns
  - Commitment to comply with treatment and to develop new health-related behaviors

### **Beliefs and Attitudes in Integrated SRH Counseling**

*Beliefs* are important to individuals. They help us to explain how things “work” in the world—what is right and what is wrong. They usually reflect our values, which are influenced by religion, education, culture, and family and personal experiences.

## Session 10

Our beliefs and values shape our *attitudes*, or the way that we think about and act toward particular people or ideas. Consider the following statements, which reflect a range of opinions about SRH (but not necessarily those of EngenderHealth or your trainers). How these statements make you feel, and what you believe about these topics, can affect the way you provide services to clients. In this way, your attitudes and beliefs may have both positive and negative impacts on clients and on their decision making regarding SRH. However, our beliefs and attitudes often are so ingrained that we may be unaware of them until we are confronted with a situation that challenges them.

**"A woman who knows she is infected with HIV  
should not have a baby."**

"Homosexuals can change  
if they really want to."

"AIDS is mostly a problem  
of prostitutes."

**"Celibacy goes against human nature."**

**"CHILDREN SHOULD BE TAUGHT ABOUT  
HIV AND OTHER STIS IN SCHOOL."**

How we communicate our beliefs and attitudes (both verbally and nonverbally) is an important part of our interactions with clients. Our attitudes, feelings, biases, and values affect how we treat a client's problems, needs, and concerns. For example, our private reaction to the client's looks, social class, reason for seeking health care, or sexual behavior may affect our tone of voice and ability to make eye contact, the gentleness or harshness with which we perform procedures, the delay that we may impose on clients, and whether we consider the full range of health care needs of each client.

Every interaction between health care staff and clients—from the time they enter the health care system until they leave—affects clients' comfort and their satisfaction with the care they received, how well they carry out decisions made during the counseling session, and whether they come back for follow-up or if problems arise. Regardless of your personal beliefs, as a health care provider you have a professional responsibility to offer SRH care in a respectful and nonjudgmental manner. Being aware of your own beliefs can help you identify the potential for being judgmental and alter your behavior, so as to avoid it and the negative effects that this can have on clients.

## Session 11 Sexuality

By the end of this session, you should be able to:

- Identify (to yourself) how your personal experiences of sexual development and learning can affect your current views and feelings about sexuality issues
- Explain how your own views and feelings about sexuality might influence your approach to counseling clients on these issues
- List four elements of sexuality and describe how they encompass much of our life experience
- Describe milestones in sexual and social development

### *Essential Ideas—Session 11*

#### *Part A: Reflections on How We Learned about Sexuality*

- Our own beliefs and attitudes about sexuality and sexual practices may affect how we talk to our clients about sexuality, as well as our comfort in doing so. Perceiving where our own feelings and beliefs came from can help us empathize with the experiences of clients and understand the difficulties we all have in talking about our sexuality.
- Sexual practices and relationships are affected by the way we feel about sex, what we think is proper and improper, and what it means to relate to another person in a sexual way. These types of thoughts and feelings are often filled with emotions, including pleasure and sometimes fear, guilt, shame, or embarrassment. These feelings come from our personal experiences and also from the meanings that our society and culture attach to sex.
- This exercise alone might not help us to feel more comfortable discussing sexuality with our clients, but it can be a helpful step in the process.

#### *Part B: Aspects of Sexuality*

- Four aspects of sexuality—sensuality, intimacy and relationships, sexual identity, and sexual health—encompass much of our life experience. Being able to appreciate the complexity of sexuality in our clients' lives may help us to be able to address sexuality in a more understanding way and to address sexuality-related issues beyond sexual behaviors and intercourse. These issues play an important role in how our clients make SRH-related decisions.

*(continued)*

*Essential Ideas—Session 11 (continued)*

*Part C: Sexual and Social Development*

- Sexual development is a lifelong process, combining our bodies' changing needs with the messages that we constantly receive from our social environment about what is "normal" and about how to fulfill our needs for physical and emotional closeness.
- Early influences in a client's life may result in unhealthy behaviors as an adult. It is important to help the client understand how or why he or she is unhealthy and to find acceptable ways of changing those behaviors. We can also acknowledge the needs of young people for information and reassurance about SRH, as well as the needs of older adults for information, reassurance, and health care services that support their continuing sexual expression and health beyond the reproductive years.

## Participant Worksheet

### Reflections on How We Learned about Sexuality

Spend the next 60 seconds writing down (on a separate piece of paper) all of the words that come to mind when you think of how you learned about sexuality. Write whatever comes to mind. Keep your pen to the paper and write for the entire 60 seconds. It will be for your eyes only, and you can destroy it when you have finished.

Now do the same for beliefs and attitudes that you have about sexuality and sexual practices.

Then, think about the following questions to see how this relates to your work in integrated SRH counseling:

- How do *your* experiences, beliefs, and attitudes concerning sexuality affect the way you talk with clients?
- How do you think *clients'* experiences, beliefs, and attitudes concerning sexuality affect their ability to talk with you?
- How do you feel when discussing sexuality or sexual practices with clients?
- How do you think clients feel when discussing these topics with you?
- What can you do to make yourself or your clients more comfortable with discussing sexuality or sexual practices in the clinic setting?

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

## Background Materials

### *Aspects of Sexuality*

*Sexuality* is an expression of who we are as human beings. Sexuality includes all of the feelings, thoughts, and behaviors related to being male or female, to being attractive and being in love, as well as to being in relationships that include intimacy and physical sexual activity.

Sexuality begins before birth and lasts throughout a person's life span. Our sexuality is shaped by our values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, spirituality, and all of the ways in which we have been socialized. Consequently, the ways in which an individual expresses his or her sexuality are influenced by ethical, spiritual, cultural, and moral factors.

### *Four Aspects of Sexuality*

1. **Sensuality** is how our bodies derive pleasure. It is the part of our experience that deals with the five *senses*: touch, sight, hearing, smell, and taste. Any of these senses, when enjoyed, can be "sensual." Sensuality is also part of the sexual response cycle, because it is the mechanism that enables us to enjoy and respond to sexual pleasure.

Our body image is part of our sensuality. Whether we feel attractive and proud of our body influences many aspects of our lives.

Our need to be touched and held by others in loving and caring ways is called *skin hunger*. Adolescents typically receive less touch from family members than do young children. Therefore, many teenagers satisfy their skin hunger through close physical contact with a peer. Sexual intercourse may result from a teenager's need to be held, rather than from sexual desire.

2. **Intimacy** is the part of sexuality that deals with the emotional aspect of *relationships*. Our ability to love, trust, and care for others is based on our levels of intimacy. We learn about intimacy from those relationships around us, particularly those within our families.

Emotional risk-taking is part of intimacy. To have true intimacy with others, a person must open up and share feelings and personal information. We take a risk when we do this, but intimacy is not possible otherwise.

3. Every individual has his or her own personal **sexual identity**. This can be divided into four main elements:

- **Biological sex** is based on our physical status of being either male or female.
- **Gender identity** is how we feel about being male or female. Gender identity starts to form around age 2, when a little boy or girl realizes that he or she is different from people of the opposite sex.
- **Gender roles** are society's expectations of us, based on our biological sex. What behaviors do we expect of men and what behaviors do we expect of women? And when did we learn to expect these behaviors? These expectations are gender roles, and they begin to form very early in life.
- **Sexual orientation** is the final element of sexual identity. Sexual orientation refers to the biological sex to which we are attracted romantically. Our orientation can be heterosexual

(attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. However, they actually are expressing different gender roles: Their masculine or feminine behavior has nothing to do with their sexual orientation. A homosexual man may be very feminine, very masculine, or neither; the same applies to heterosexual men. Also, a person may engage in same-sex behavior and not consider himself or herself homosexual.

4. **Sexual health** involves our behavior related to producing children, enjoying sexual relationships, and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy, and STIs are part of our sexual health. It also refers to the right to exercise control over one's sexuality free of coercion or violence (see Session 2 for more information on sexual health).

*Note:* This section was adapted from: EngenderHealth, 2003b.

## Sexual and Social Development

Worldwide, people reach many milestones in sexual and social development at generally the same age, although they may follow patterns that vary from culture to culture.

When you review the following information, it is important to remember that some of these milestones are indications of normal physical development, some are common behavioral reactions to physiological development, and some are culturally determined norms. In every culture, a great many individuals have experiences that do not conform to their society's norms and mores. In your dealings with clients, be careful not to assume that all clients' behaviors will adhere to the societal norm.

### ***Milestones in Male and Female Sexual and Social Development***

- *Begins to have sexual responses.* Occurs before birth. A male fetus achieves genital erections in utero; some males are even born with erections. Sexual responses in females are also believed to occur before birth.
- *Explores one's own genitals (masturbates) for the first time.* Occurs between ages 6 months and 1 year. As soon as babies can touch their genitals, they begin to explore their bodies.
- *Shows an understanding of gender identity.* Occurs by age 2. Children are aware of their biological sex.
- *Shows an understanding of gender roles.* Occurs between ages 3 and 5. Children begin to conform to society's messages about how males and females should act.
- *Asks questions about where babies come from.* Occurs between ages 3 and 5.
- *Begins to show romantic interest.* Occurs by ages 5 to 12, although this may vary by culture. At this stage, children show the first signs of sexual orientation (sexual preference toward males or females).
- *Shows the first physical signs of puberty (the transition from childhood to maturation).* Occurs by ages 8 to 12. This usually occurs slightly earlier for girls than for boys.

## Session 11

- *Begins to produce sperm (boys)*. Occurs between ages 11 and 18. This milestone depends in part on the child's nutrition and may be delayed where nutrition is severely compromised.
- *Begins to menstruate (girls)*. Occurs between ages 9 and 16. This milestone depends in part on the child's nutrition and may be delayed where nutrition is severely compromised.
- *Begins to engage in romantic activity*. Occurs by ages 10 to 15. This milestone depends heavily on cultural factors.
- *Has sex for the first time*. This varies greatly by culture, but mid-to-late adolescence is fairly common across cultures. Many societies have cultural taboos against sexual experience outside of a traditional heterosexual marriage; in other cultures, a couple is expected to have sex—or even conceive a first child—before marriage; and in other cultures, same-sex sexual experiences are common. An individual's first sexual experience may not be consistent with what society condones. For example, in many societies, girls would be disgraced by having premarital or casual sex, whereas young men in the same culture may be expected or encouraged to have sex before marriage. This does not mean that some—or even many—girls in these cultures do not have premarital sex, but it does mean that they may be afraid to disclose any sexual experience they have had to health care workers or to others.
- *Gets married*. Timing varies greatly by culture. In some cultures, girls and boys are married very young; in others, young girls are married to older men. In some parts of the world, common-law unions are the predominant pattern. However, these relationships, like marriage, are a proxy for age at initiation of sexual activity.
- *Begins to bear children*. Many factors determine when and if a person has a first child. First childbirth varies by community and by individual. In some communities, the first child is expected to be born before marriage (as a proof of fertility) or without marriage. In other cultures, first childbirth is expected to occur after marriage, while in others, pregnancy may lead people to marry. In some cultures, couples increasingly are choosing to delay childbirth or to have no children at all, a change made possible by the availability of effective contraception and, in some cases, induced abortion.
- *Experiences menopause/male climacteric*. Menopause occurs in women at around age 50 (it can start in the late 30s or early 40s as well); male climacteric occurs between ages 45 and 65. Menopause occurs when a woman goes through a process of physiological changes characterized by the end of ovulation, menstruation, and the capacity to reproduce. Male climacteric is characterized by a decrease in testosterone production. For both sexes, this midlife process of transition results in changes in a person's physical structure, hormonal profile, and sexual functioning.
- *Experiences sexuality in later life*. Older adults (those aged 50 to 60 or beyond) can remain sexually active to the end of their life. Though some age-related changes in sexuality take place, the total loss of sexual functioning is not a part of the normal aging process. Biological changes, illnesses, therapies for those illnesses, and psychological and social factors can affect sexuality and sexual functioning.

*Note:* This section was adapted from: EngenderHealth, 2000, pp. 3.6–3.7.

## Participant Worksheet

### Sexual and Social Development

Throughout the world, people develop sexually and socially throughout their lives. Please number the following milestones from first to last (1 for the first milestone to occur in a person's life, 2 for the second, etc.). Then compare your answers with the milestones described on page 54. Your answers could be somewhat different, due to variations in individual experience or to variations in cultural norms. However, the basic developmental steps seem to be remarkably similar across cultures.

- \_\_\_\_\_ Begins to menstruate (girls)
- \_\_\_\_\_ Begins to show romantic interest
- \_\_\_\_\_ Shows an understanding of gender identity
- \_\_\_\_\_ Has sex for the first time
- \_\_\_\_\_ Begins to bear children
- \_\_\_\_\_ Explores one's own genitals (masturbates) for the first time
- \_\_\_\_\_ Experiences sexuality in later life
- \_\_\_\_\_ Experiences menopause/male climacteric
- \_\_\_\_\_ Begins to have sexual responses
- \_\_\_\_\_ Asks questions about where babies come from
- \_\_\_\_\_ Shows an understanding of gender roles
- \_\_\_\_\_ Gets married
- \_\_\_\_\_ Begins to engage in romantic activity
- \_\_\_\_\_ Shows the first physical signs of puberty (the transition from childhood to maturation)
- \_\_\_\_\_ Begins to produce sperm (boys)

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

## Session 12

### Variations in Sexual Behavior

By the end of this session, you should be able to:

- Identify your own biases and judgments related to various sexual behaviors
- Recognize differences in individual and cultural perspectives about sexual behavior, including differences in what is considered “normal” or “acceptable”
- Explain why it is important to be nonjudgmental about sexual behaviors when counseling clients about SRH
- Be more comfortable when discussing a range of sexual behaviors with clients

#### *Essential Ideas—Session 12*

- Although reproductive health providers have offered services for many years, rarely do they discuss sexual practices with clients. HIV and AIDS have heightened providers’ awareness of the need to address sexual behaviors more frankly and directly.
- This exercise is meant to help us understand how providers’ biases about sexual behaviors might affect a client’s feelings about discussing such intimate issues.
- We all make value judgments regarding sexual behaviors and the circumstances under which people engage in sexual practices, but to be effective providers we must not impose our own values on clients as we explore their individual needs and situations.
- The term *sex* is often thought to refer to penile-vaginal intercourse only, but sexual behaviors can be defined much more broadly. If you assume that “sex” means penile-vaginal intercourse, you may miss important information.
- If a provider does not address the issue of sexual practices, clients may receive inadequate or inappropriate information and may engage in behaviors that increase their risk of infection or unintended pregnancy. Assumptions and misunderstandings about clients’ sexual practices can leave them without the information, skills, or methods they need to protect themselves.

## Session 13

# Building Rapport with Male Clients and with Adolescent Clients

By the end of this session, you should be able to:

- Describe the special needs and concerns of two types of clients—men and adolescents
- Explain the importance of building rapport immediately with male clients and adolescents
- Describe how providers can build rapport with male clients and adolescents

### *Essential Ideas—Session 13*

- In providing integrated SRH counseling, it is important to be able to meet the needs of all individuals. Most providers are accustomed to dealing with only married, female clients, and may feel awkward talking with men or with unmarried adolescents. In addition, cultural barriers may make it even more difficult to discuss sexuality concerns with someone of the opposite sex or with an unmarried youth.
- These communication barriers make men's and adolescents' needs for integrated SRH counseling more acute, as they often cannot get information or services that they need to *prevent* unintended pregnancy or HIV and STIs and may be accessing services only because they already have a serious problem.
- The purpose of this session is to help you to appreciate the needs and special concerns of these clients, to take the first step toward making such clients feel welcome and comfortable.

### **Understanding Men's Needs and Roles**

Providers who are about to start working with men often report wanting more training on how to talk to men in counseling sessions. Many are aware that there may be differences between how to talk with men about sexuality issues and how they work with women in traditional family planning counseling. While it is impossible to generalize communication approaches that work best for all men, an understanding of men's needs and roles might help providers engage men more successfully in discussions of sexuality and sexual health.

The following are some characteristics of men that have been identified through cross-cultural research on men's needs and roles. Again, these characteristics do not define all men, but rather provide a framework for considering approaches to communicating with men.

## Session 13

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## Session 13

### ***Men Are Decision Makers***

Men are usually socialized to act decisively and to be in control. This can cause conflict when a man visits a health facility, either alone or with his partner, and essentially is told what to do. Men are generally more comfortable if they can make their own decisions. A provider can help facilitate this process by affirming that a man's health-seeking behavior (i.e., coming to the clinic) is appropriate and then by probing about what decisions he is considering. If he is not sure, the provider can help affirm his ability to make decisions by asking the client how he has handled other problematic situations in his life. If he is still not sure, the provider can suggest a number of decisions he could make in this situation, rather than telling him or giving orders.

#### ***Scenario***

A man has come to your health facility because he had unprotected sex and is concerned he may have contracted an STI.

***What might not work:*** The provider might simply tell the man that unprotected sex puts him at risk for STIs, show him how to use a condom, give him condoms, and then tell him that he needs to use one every time he has sex.

***What might work:*** The provider might say: "You made a really good decision to come here today for help. You have told me that there are times you have successfully used condoms in the past. What do you think worked for you when you used condoms? How might you make sure you use condoms every time in the future?"

### ***Men May Be Reluctant to Appear Ignorant***

Men are often socialized to know it all when it comes to sex. Admitting that they might not know something, especially something related to sex, creates anxiety for men who are concerned about their sense of manhood. In a counseling session, this may be a problem if the provider is expecting a man to ask questions or ask for clarification on issues, or if the provider asks men questions such as "Do you have any questions about that?" or "Do you understand what I am saying?" Men are not likely to ask questions or to admit that they do not understand.

One technique providers can use to address this is to make it okay for men not to know. Instead of asking men to acknowledge what they do not know, providers can take the burden off a man by proactively giving him information without making him appear ignorant.

#### ***Scenario***

A provider is about to do a condom demonstration for a man.

***What might not work:*** The provider might ask the man if he knows how to correctly put on a condom, the man might reply "yes," and the provider would not do the demonstration. Or the provider might do a condom demonstration and then ask, "Do you have any questions?"

***What might work:*** The provider might say: "I am sure you already know how to put on a condom correctly, but why don't I just review a few important points about what some men struggle with..."

### ***Men May Be More Comfortable with Thoughts and Actions Than with Emotions***

In general, men are more comfortable with concrete, cognitive thinking, and are less comfortable than women are with discussing feelings. In a counseling session, the provider might focus on thoughts and decision-making steps rather than on a discussion of emotions. If you ask a man how he *felt* when he found out that his partner was pregnant, he might not be quick to describe his feelings, but if you ask him what *thoughts* were going through his mind, he may be more likely to begin discussing this. He will likely be more comfortable with talking about what he thinks he should *do* in relation to the unintended pregnancy than with discussing how he feels.

#### ***Scenario***

A man comes to a health facility to be tested for an STI. During the screening process, the man reveals that his partner has just found out that she is pregnant. It is an unintended pregnancy.

***What might not work:*** The provider might ask the man: “Your partner just found out she is pregnant? How do you feel about that?”

***What might work:*** The provider might say: “I really appreciate your sharing this news about your partner’s pregnancy. That is not an easy thing to do, but it was a good idea to bring it up. It sounds as if you have been thinking about this a lot. What have you been thinking? What do you want to do to help her?”

### ***Men Like to Know That Other Men Share Their Fears and Concerns***

A man may be more comfortable with discussing his feelings if the provider validates that his fears or concerns are normal and that other men have shared similar sentiments. If the provider suspects that a man has a concern that he is not communicating, the provider can talk about that issue in terms of what other men like him have shared in the past. In addition, a man is likely to be more comfortable, confident, and open to discussing confusion, fear, or other feelings *after* his immediate needs have been met.

#### ***Scenario***

A man has come to a health facility for STI screening. After his examination is completed, he seems to be looking through a brochure on erectile dysfunction on the desk.

***What might not work:*** The provider might ask the man: “Are you looking at that brochure on erectile dysfunction? Is there something you want to talk about?”

***What might work:*** The provider might say: “I see you are looking at our most popular brochure. You know, many men are concerned about erectile dysfunction. There was a man in here the other day who asked me about treatment, and I told him that a lot of men have been having success using....”

**Sample Phrases to Use When Addressing Men, Based on Their Needs and Roles**

Need or role	Sample phrase
Men are decision makers and want to solve their own problems	<p>“You made a really good decision to come here for help today.”</p> <p>“You made a good decision to use a condom that time.”</p> <p>“It was a good decision to talk to your partner about contraception.”</p> <p>“How will you let the people you have had sex with know that they need to come in to be checked for this infection?”</p> <p>“How do you plan to talk to your partner about this problem?”</p>
Men are supposed to know it all when it comes to sex	<p>“You may already know this, but...”</p> <p>“You have probably heard this before, but I have to tell all of my clients that...”</p> <p>“I am sure you already know how to put on a condom correctly, but why don’t we just review a few important points about...”</p> <p>“Let me just point out a few tips for you.”</p> <p>“I would like to be sure you understand how you got that disease.”</p>
Men might not ask questions about sex	<p>“There was a man in here the other day, and he asked me about erectile dysfunction, and let me tell you what I told him.”</p> <p>“Even when we have dealt effectively with a problem, we sometimes have a few remaining doubts afterward. Is there anything more you would like to discuss with me?”</p> <p>“You seem to understand in general how to use condoms, but are there any points you would like to know a little more about?”</p> <p>“As long as you are here today, are there any things you would like to ask or tell me about?”</p>
Men want to know that they are “normal” and as good as or better than other men	<p>“Many men are concerned about the same thing.”</p> <p>“You know, many men have asked that question before.”</p> <p>“A lot of men wonder about that.”</p>
Men may need validation for asking questions about sex	<p>“That is a really good question.”</p> <p>“I am glad you asked about that.”</p> <p>“You are really brave to ask that.”</p> <p>“It is great that you came here to get more information about that.”</p>

*Adapted from: EngenderHealth, 2003b.*

## SRH Services and Counseling for Adolescents

The two main reasons why SRH programs should offer counseling and clinical services to adolescents are:

- Young people have a *right* to quality reproductive health services.
- Young people *need* reproductive health services.

Reasons why adolescents may be at risk for SRH problems include:

- Lack of knowledge and information
- Lack of access to services and programs
- Psychological and social barriers to accessing services

SRH services and counseling can help adolescents:

- Protect and improve their current health
- Understand their sexuality and SRH needs
- Learn to take active responsibility for their reproductive health
- Prevent unintended pregnancies
- Prevent serious health problems and premature death due to complications from a pregnancy that occurs too early or from an unsafe abortion
- Avoid STIs
- Make informed choices about SRH
- Ensure a healthy future

When counseling young people, providers have a responsibility to:

- Be a *reliable*, factual source of information about SRH, including pregnancy and STI prevention
- Create an atmosphere of *privacy*, *respect*, and *trust*, so that young people will feel free to ask questions, voice concerns, and discuss intimate sexual issues
- Engage in a *dialogue* or open discussion with the young person
- Offer choices, not judge the young person's decision, and accept his or her right to choose and the choices made

*Note:* Adapted from: Barnett & Schueller, 2000, Chapters 1, 2, and 6.

# Communication Skills

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Good counseling requires good communication skills. The abilities to establish rapport, to elicit information, and to provide information effectively are necessary to support clients' informed and voluntary decision making. To effectively assess clients' needs, providers need to couple open-ended questions that encourage clients to talk about themselves with active listening skills and effective paraphrasing, to ensure comprehension. To give appropriate information, providers must be able to communicate their knowledge about SRH issues effectively. This requires the ability to explain things in language and terms the client understands (with or without the help of visual aids), and comfort in talking about issues related to sexuality. Developing rapport was introduced in Session 9. The training sessions that follow introduce the other essential communication skills.

# Session 14

## Asking Open-Ended Questions

By the end of this session, you should be able to:

- Describe two basic types of questions used when communicating with SRH clients
- Explain the importance of open-ended (and feeling/opinion) questions in assessing clients' needs and knowledge
- Reformulate closed-ended questions into open-ended questions
- Identify open-ended questions with which to explore sexuality issues related to HIV and STI risk, antenatal, postpartum, and family planning concerns, and other SRH issues

### *Essential Ideas—Session 14*

- Asking questions is important if a provider is to accurately assess a client's SRH needs and knowledge early in the counseling and to actively involve the client throughout the session.
- There are two categories of questions, based on the kind of answer that they bring forth. *Closed-ended* questions usually require only a very short response, often just one word. *Open-ended* questions allow the possibility of longer responses and often involve the client's opinion or feelings.
- Both types of questions have important roles in integrated SRH counseling. However, providers have historically relied much too heavily on closed-ended questions and thus have limited clients' involvement in information sharing and decision making. Being able to ask more open-ended questions will make it easier for you to help clients explore their options and feelings.

### **Why Do We Ask Questions during Integrated SRH Counseling?**

- To assess the client's SRH needs and knowledge
- To involve the client as an active partner and elicit his or her needs, concerns, and preferences
- To establish a good relationship by showing concern and interest
- To prioritize the key issues to target during the (normally) brief time available for counseling
- To determine what educational or language level will be best understood by the client
- To avoid repeating information that the client already knows
- To identify areas of misinformation to correct

*Note:* Adapted from: Tabbutt, 1995.

## Session 14

### Types of Questions

*Closed-ended questions* usually will be answered with a very short response, often just one word. A closed-ended question calls for a brief, exact reply, such as “yes,” “no,” or a number or fact. These are good questions for gathering important medical and background information quickly. Examples include:

- How old are you?
- How many children do you have?
- When was your last menstrual period?
- When did the bleeding start? (for postabortion care clients)

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

- How can we help you today?
- What do you think could have caused this problem?
- What have you heard about this family planning method?
- [For postabortion care clients] How did you feel when you first found out you were pregnant? How do you feel now?
- What questions or concerns does your husband/partner have about your condition?
- What do you plan to do to protect yourself from getting a sexually transmitted infection again?
- What made you decide to use the same method as your sister?

*Note:* Adapted from: EngenderHealth, 2003c.

## Participant Worksheet

### Asking Open-Ended Questions about SRH Concerns

**Instructions:** For each area below, identify questions to ask the client to get information or to determine the client's concerns about the topic. This list of issues should *not* be used as a checklist; it is merely a guide to help you remember some of the points that are important to cover. Remember to use open-ended questions as much as possible.

#### *Family Planning*

What questions would you ask clients about:

- Reproductive intentions (i.e., plans for number and timing of pregnancies)
- Feelings about the possibility of becoming pregnant
- Knowledge of contraceptive methods
- Previous contraceptive use, if any
- The impact on sexual pleasure of contraceptive methods (e.g., condoms or other barrier methods)
- Partner's attitudes about contraception in general and about specific methods
- Fear of specific methods because of rumors or the experiences of others

#### *HIV and STIs*

What questions would you ask clients about:

- Knowledge about HIV and sexually transmitted infections (STIs), including how they are transmitted and the symptoms or signs that someone has an STI or HIV
- Knowledge about how to avoid getting an STI or HIV
- History of STIs or other infections
- Number (and gender) of sexual partners currently and in the past
- Knowledge of partner's sexual practices and other partners
- Condom use
- Sexual practices and behaviors

#### *Antenatal and Postpartum*

What questions would you ask an antenatal or postpartum client about:

- Previous pregnancy and delivery experience (if any)
- Physical changes during normal pregnancy
- Diet and nutrition during pregnancy and breastfeeding
- Work and activity level during pregnancy
- Danger signs during pregnancy
- Sexual activity during pregnancy
- Contraception after pregnancy

*(continued)*

## Participant Worksheet

### Asking Open-Ended Questions about SRH Concerns (*continued*)

#### *Antenatal and Postpartum (continued)*

- Plans for delivery, including emergency situations
- Breastfeeding
- Sexual activity after delivery
- Postpartum danger signs
- Immunization for the newborn

#### *Postabortion*

What questions would you ask a postabortion care client about:

- Her current physical condition
- Her current emotional condition
- Her understanding of what is happening to her body
- What to expect during the procedure
- Possible side effects and complications
- Return to fertility
- Her plans for conception or contraception after procedure
- Her exposure to HIV or other STIs
- Her need for other health or social services

#### *Sexuality Issues for Any Client*

What questions would you ask any client about:

- Past surgery or diseases relevant to sexual functioning
- Infertility concerns
- Breast self-examination (for women) or prostate examination (for men)
- Sexual concerns with the onset of menopause (if appropriate)
- Problems with sexual activity (e.g., sexual dysfunction in the client or his or her partner, pain during sex, insufficient lubrication [for women], or lack of desire, orgasm, or sexual satisfaction)
- Impact of drug or alcohol use on sexual activity and risks
- Experience with female genital mutilation
- Experience of recent or past sexual coercion or violence

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

## Session 15

# Listening and Paraphrasing

By the end of this session, you should be able to:

- Describe at least two purposes of listening as a key communication skill for counseling
- List at least three indicators of effective listening
- Name at least two purposes of paraphrasing in counseling
- Demonstrate paraphrasing

### *Essential Ideas—Session 15*

- *Effective listening* is a primary tool for showing respect and establishing rapport with the client. When a provider does not listen well, it is easy for a client to assume that his or her situation is not important to the provider, or that he or she as an individual is not important to the provider. Thus, it is hard to develop the trust necessary for good counseling if the provider is not listening effectively.
- Effective listening is also a key communication skill for counseling. It is important for most efficiently determining what the client needs, what the client's real concerns are, and what the client already knows about his or her situation.
- Listening skills can be improved by:
  - Maintaining eye contact with the speaker (within cultural norms)
  - Being attentive to the speaker (e.g., not doing other tasks at the same time)
  - Not interrupting
  - Showing interest by nodding, leaning toward the client, and smiling
- *Paraphrasing* means restating the client's message simply and in your own words. The purposes of paraphrasing are to:
  - Make sure you have understood the client correctly
  - Let the client know that you are *trying* to understand his or her basic messages
  - Summarize or clarify what the client is trying to say

## Session 15

### Effective Listening

Listening skills can be improved by:

- Maintaining eye contact with the speaker (within cultural norms)
- Demonstrating interest by nodding, leaning toward the client, and smiling
- Sitting comfortably and avoiding distracting movements
- Paying attention to the speaker (e.g., not doing other tasks at the same time, not talking to other people, not interrupting, and not allowing others to interrupt)
- Listening to your client carefully, instead of thinking about other things or about what you are going to say next
- Listening to *what* your clients say and *how* they say it, and noticing the client's tone of voice, choice of words, facial expressions, and gestures
- Imagining yourself in your client's situation as you listen
- Keeping silent sometimes, and thus giving your client time to think, ask questions, and talk

*Note:* Adapted from: EngenderHealth, 2003c; and Rinehart, Rudy, & Drennan, 1998.

## Participant Worksheet

### Listening and Paraphrasing

You are a female client who is married. You know that your husband has other sexual partners and you have recently had an unusual discharge from your vagina. You have come to the clinic for family planning counseling, but you hope to be able to ask about the discharge. When it is your turn to meet with the provider, you are surprised to find that others are around and can easily hear your conversation. During the counseling session, the provider is very distracted. She looks everywhere but at you. She talks with other health care staff and does not seem to hear or care about what you are saying.

After you say that you have come for family planning, the provider asks only for your age and how many children you have. She does not ask you any questions pertaining to your personal situation and does not listen when you try to explain about the discharge. You decide that the provider must know more than you do and that your opinion must not be worth expressing, so you stop talking. The provider ends the counseling session by telling you that oral contraceptives would be best for your needs and to pick them up from the receptionist on your way out.

If you were this client, how would you answer the following questions?

- How did you feel about this counseling session?
- What made you think that the provider was not listening to you?
- How did you feel when the provider did not listen to you?
- What could the provider have done to assess your needs better?

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## Session 16

# Using Language That Clients Can Understand

By the end of this session, you should be able to:

- Be more comfortable using sexual terminology with clients
- Refer to local words for sexual acts and body parts, to make the link between the words that the client understands and words that you are comfortable using
- Demonstrate the use of simple language to explain sexual and reproductive anatomy and physiology to clients

### *Essential Ideas—Session 16*

#### *Part A: Language and Sexuality*

- One challenge that people confront in discussing matters related to sexuality and SRH is in choosing the words to use. Sometimes the words that come to mind seem either too clinical or too offensive. However, to communicate effectively, you as a provider must know the words that a client would understand.
- You should not feel obliged to use throughout the counseling session words that you consider offensive. However, it is important to be able to identify the word a client uses for a particular body part or activity and then explain to the client that, when a particular medical term is used, it is referring to that.
- If you are comfortable enough to use local words as a bridge for understanding, it will help the client to overcome his or her own embarrassment at discussing these subjects. An important part of this training process is for you to say the words out loud, so you begin to feel more comfortable about using them or hearing them from clients.

#### *Part B: Using Simple Language*

- For effective communication, it is essential to explain issues of SRH in ways that clients understand. Even when we feel that we know something very well, it can be hard to find simple ways to explain. This gets easier with practice.

*(continued)*

*Essential Ideas—Session 16 (continued)*

- Asking what the client already knows is essential. It lets us know what level of terminology—e.g., slang, common words, or medical terms—the client will understand. This also gives you a starting point, by reinforcing the client’s current knowledge and correcting inaccuracies.
- Not finding out first what the client already knows can lead to two common errors: explaining at a level beyond his or her comprehension, or wasting time explaining what he or she already knows (perhaps insulting the client in the process).
- There is rarely enough time in counseling to adequately explain everything that the client needs to know. This process is much more efficient if the basic information about anatomy and physiology and key medical terms are explained in group-education sessions prior to counseling. Then, during counseling, you can quickly review the information to see what the client did or did not understand and what questions he or she might have.

**Sexual and Reproductive Anatomy and Physiology:  
Using Language Clients Can Understand**

*Female Anatomy and Physiology*

The **ovaries** produce eggs and female hormones. Female hormones give women their female characteristics (like breasts and the way their voices sound) and their sex drive. The woman’s ovaries release an egg once a month (**ovulation**).

The **fallopian tubes** connect each ovary with the **uterus**, or **womb**. When the egg leaves the ovary after ovulation, it travels through one of the fallopian tubes to the uterus. **Fertilization (conception)** is when the man’s **sperm** (“seed”) enters the egg; this usually happens in the fallopian tube.

**Pregnancy** occurs when a fertilized egg travels down the fallopian tube and attaches itself to the wall of the **uterus**. This is where the fertilized egg grows into a baby, over the course of nine months.

When a woman of reproductive age is not pregnant, every month the uterus sheds its lining, which is mostly blood. This is called **menstruation**.

The **cervix** is the narrow neck of the uterus that connects the uterus with the vagina. The **vagina** is the passage that connects the uterus with the outside of the body. Menstrual blood and babies are expelled from the woman’s body through the cervix and then through the vagina. The cervix has to widen to let a baby through, which is what happens when a pregnant woman goes into labor. To start a pregnancy, a man and a woman have sexual intercourse and the man ejaculates in the woman’s vagina. The sperm then travel from the vagina through the cervix and the uterus until it reaches the fallopian tubes.

The **clitoris** is a small bud of tissue, covered with a soft fold of skin, that is located above the urinary opening, which is just above the opening to the vagina. It is very sensitive to touch. During sexual arousal, the clitoris swells and becomes erect. It plays an important role in a woman's sexual pleasure and climax (**orgasm**). The **vulva** is the area around the opening of the vagina, including the folds of skin (**labia**), the clitoris, the urinary opening, and the opening to the vagina itself.

### **Male Anatomy and Physiology**

The **scrotum** is the sack of skin that holds the two testicles.

The **testicles** produce sperm and male hormones. Male hormones give men their masculine characteristics (such as facial hair and muscles) and their sex drive (desire for sexual intercourse).

**Sperm** are the man's "seeds," the cells that need to join with a woman's egg for fertilization. After being produced in the testicles, the sperm are stored in the **epididymis**, a long curled-up tube above each testicle.

When the man's body is ready to release sperm, the sperm leave the epididymis and travel through the **vas deferens**. (One vas deferens leads from each testicle.) Each vas deferens loops over the bladder and joins the **seminal vesicles**, two pouches located on either side of the prostate gland. These add a fluid that energizes the sperm.

The **prostate gland** is located at the base of the bladder. It produces the majority of the fluid that makes up semen. The prostate fluid is alkaline (basic), which is needed to protect the sperm from the acid environment in the woman's vagina.

**Semen** is the liquid that comes out of the penis when a man climaxes. It contains sperm and fluids from the seminal vesicles and the prostate gland. Sperm make up only a tiny amount of the semen. After a man has a **vasectomy**, the semen is still produced but it no longer contains sperm.

The semen passes from the prostate gland, through the **urethra**, and out through the **penis**. During **sexual intercourse**, the man puts his penis into the woman's vagina and semen is released (**ejaculation**). The urethra is also the tube that carries urine from the bladder when a man urinates. However, when a man ejaculates, a valve at the base of the bladder closes, so that no urine can come out with the semen.

**Cowper's glands** are two small glands that release clear fluid into the penis just before ejaculation. Their purpose is probably to help clean out the acid in the urethra (from urine) before the sperm pass through. This fluid could also contain some sperm or infectious microorganisms. Since the man cannot feel or control this fluid when it comes out, it is important for him to use a condom for all contact between his partner and his penis, if there is any concern about protection against pregnancy or disease.

### **Other Terms**

When a couple has sex but the man or woman (or both) do something to stop the man's seed from joining the egg, this is known as **contraception**.

## Session 16

The **genitals** are the external sexual organs, usually considered to include the penis, scrotum, vagina, labia, or clitoris.

**Oral sex** is when one partner uses his or her mouth, lips, or tongue to stimulate the other partner's genitals. **Anal sex** is when one partner stimulates his or her partner's anus with his or her fingers, penis, lips, tongue, or other objects. Oral sex and anal sex carry no risk of pregnancy. However, sexual infections, including HIV, can be passed in this way, because body fluids and the germs or microorganisms that cause infections can be shared between partners. (*Adapted from: EngenderHealth, 2000.*)

A **miscarriage** occurs when a woman is pregnant but the lining of the womb comes out of the womb, along with the developing baby, before the developing baby is old enough to survive outside the womb. This ends the pregnancy.

An **abortion** is when a pregnancy is ended prematurely (before survival outside the uterus is possible). Abortions may be spontaneous (i.e., a miscarriage) or induced (when the woman does something to end the pregnancy).

In countries where **female genital cutting** is practiced, some women may have either the clitoris, or the clitoris and labia, removed. In some cases, the labia may be sewn together. Sometimes this is called female genital mutilation or female circumcision. (*Adapted from: Arkutu, 1995.*)

**Sexually transmitted infections (STIs)** are infections passed from person to person, primarily by sexual contact. They are also known as sexually transmitted diseases (STDs) or venereal disease (VD). Some STIs can be passed to a baby during pregnancy, delivery, or breastfeeding. Others can be passed through unclean surgical instruments, injection needles, and skin-cutting tools, as well as through blood transfusions.

**Discharge** is anything moist that comes from the vagina or penis, not including urine. There is "normal" discharge, such as blood during a woman's menstruation and a clear, slippery or sticky wetness that she might feel around the time of ovulation. However, when the wetness looks or smells different, this may be a sign of an STI; this applies to both men and women. The discharge might be white, yellow, or slightly greenish; it might smell like yeast or cheese.

*Note:* Except where otherwise noted, information presented here is adapted from: AVSC International, 1995.

## Session 17

# Using Visual Aids to Explain Reproductive Anatomy and Physiology

By the end of this session, you should be able to:

- Develop your own simple visual aids to use to explain the reproductive system to clients
- Explain the importance of being able to draw the reproductive system, even if you never do this with clients

### *Essential Ideas—Session 17*

- The idea behind this session is that if you can draw the reproductive system, you will be *much* better able to explain it in simple and clear terms. There are several reasons why this might be true:
  - ▶ Drawing makes you focus and remember the organs and what they do
  - ▶ Having more knowledge makes you more confident about explaining to others and encouraging their questions
  - ▶ Learning to draw the “private parts” helps to overcome one’s own embarrassment about discussing them
- Talking about sexual body parts and processes makes a lot of people very nervous, and many people show nervousness by laughing. This is normal and good for relieving some of the tension. However, training *and* counseling must be conducted in a respectful manner. Just as making sexual jokes is not appropriate in the training setting, it should not be allowed between clients and providers either.
- Remembering how you or some of your colleagues felt when you had to draw the reproductive system here in the training may help you to empathize with how clients feel when we use visual aids without proper introduction and explanation.
- This exercise is *not* about developing “artistic” skills, but by the end most participants should be able to do a simple drawing of the male and female reproductive systems. Those who feel confident with their drawings may find it easier to explain complex internal systems to clients, particularly the male anatomy, by doing a drawing with the client, starting with the simple body outline and then, as each organ is added to the drawing, describing it and how it works. This technique may also be useful for training other health workers.

*(continued)*

*Essential Ideas—Session 17 (continued)*

- Having visual aids around the clinic space is good, but not enough to be considered “education.” Clients may be embarrassed by anatomy drawings or may be confused by the representation of internal systems. To be effective, visual aids need to be explained to clients. The first step is to ask the client what the picture looks like to him or her, to understand what the client is seeing and perceiving in the drawing. The next step is to identify organs that the client knows and then go on to those that he or she may not know.

Female Reproductive System

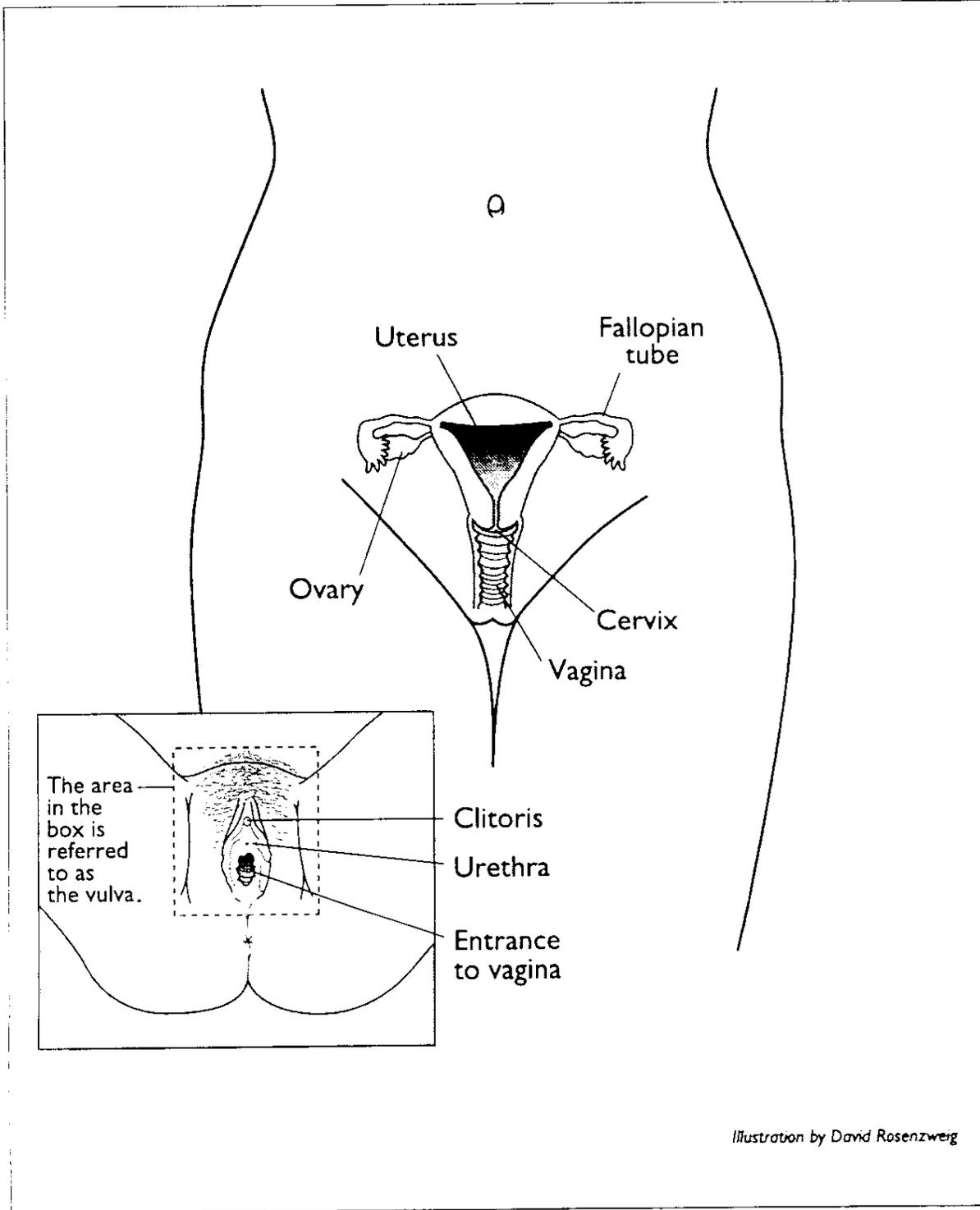
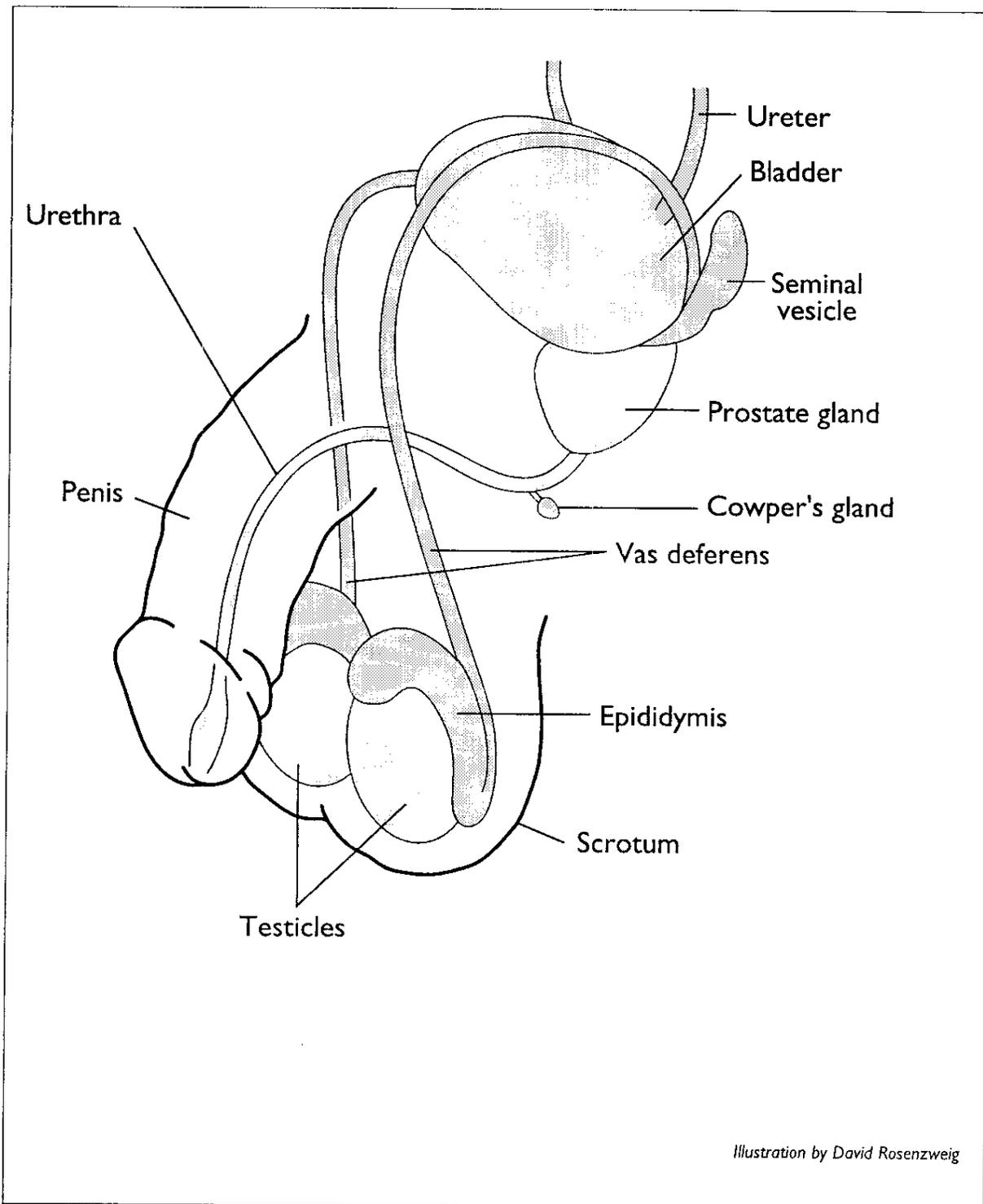


Illustration by David Rosenzweig

### Male Reproductive System



## Part IV

# Helping Clients Assess Their Comprehensive SRH Needs and Providing Appropriate Information

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In these sessions, you will begin to apply attitudes and communication skills to carry out the counseling tasks that comprise the four general objectives for this training. Helping clients to assess their own comprehensive SRH needs requires two-way communication between the client and the provider. The provider begins by asking appropriate questions; the client responds and the provider listens; the provider gives information that the client is lacking or corrects misinformation related to the client's needs; and then the provider helps the client consider how the information applies to him or her and his or her level of risk. This crucial phase of counseling thus is a combination of the first two general objectives—helping clients assess their need for a range of SRH services, information, and emotional support, and providing information appropriate to their problems and needs.

## Session 18

# Introducing the Subject of Sexuality with Clients

By the end of this session, you should be able to:

- Explain to clients why you will be discussing sensitive and personal issues during counseling, such as STIs and sexual relationships and behaviors
- List key points to cover with clients to help put them at ease in these discussions

### *Essential Ideas—Session 18*

- It is the provider's responsibility to be comfortable with introducing the subject of sexuality and to help the client feel comfortable about responding to questions concerning their sexual behavior.
- Talking about sexuality should never be the first thing that a provider addresses with the client.
- There are important points to explain to clients, to help them understand why you need to ask personal and sensitive questions and to help clients feel more at ease in answering them. When initiating a discussion about sexuality:
  - ▶ Explain the reasons for asking questions about sexuality
  - ▶ Explain the importance of discussing HIV and STIs, and assure the client that you discuss this topic with all clients
  - ▶ Note that what is shared in counseling is confidential, and then ensure privacy
  - ▶ Explain that the client does not have to answer all questions
- When working with clients, *how* a counselor or provider asks questions is just as important as *what* he or she asks. If a provider appears to be nervous or uncomfortable, the client is more likely to feel the same way. You should be aware that nonverbal communication (your body language, facial expressions, and tone of voice) can convey messages as easily as language can.

### **Introducing the Subject of Sexuality with Clients**

When counseling clients on SRH issues, providers often need to ask very personal, sensitive questions. This can be challenging for the client, who may not be accustomed to discussing such personal things with someone other than a family member or with anyone at all. It can also be challenging for providers, since they too are probably not accustomed to discussing such issues, and may fear embarrassing themselves and the client.

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## Session 18

*Talking about sexuality should never be the first thing a provider addresses with the client. It is always best to start with general, open-ended questions to establish rapport or to get the conversation rolling. Specifically, the provider should ask open-ended questions to determine the client's reason for the visit, his or her general health, and his or her particular concerns. This will help pave the way for the more sensitive questions that you will ask later.*

*There are important points to explain to clients, to help them understand why you need to ask personal and sensitive questions, and to help clients feel more at ease in answering them. You and the clients may never be totally comfortable with these discussions, but, as a provider, it is important for you to get key information about behaviors and relationships that may put the client at risk of unintended pregnancy, HIV or STIs, and other SRH problems. Your own comfort and confidence in asking such questions is a crucial factor in helping the client to feel comfortable, too.*

*The sample statements on page 87 are provided merely to give you guidelines. You should introduce the discussion in your own way, depending on what is appropriate for your culture, the service-delivery setting, the client, and the type of service that the client is seeking or the complaint that the client presents with.*

## Sample Chart

Points to explain	Sample statements
<p>To put the client at ease, <b>explain why you are asking sensitive questions</b>. Explain that this discussion may require asking personal questions about the client's sexual behavior and relationships. Assure the client that the questions have a direct bearing on the client's health care and the decisions made during the visit.</p>	<p>"I will need to ask personal questions because sexual behaviors and relationships may have something to do with your health concerns or contraceptive choices. It is important for me to ask you these types of questions so I can help you make health decisions that are right for you."</p>
<p>Explain that, given the serious nature of HIV and STIs, <b>it is the policy of your facility to discuss HIV and STIs with everyone</b>. Reassure the client that the questions are routine and that everyone is asked the same questions.</p>	<p>"As you may know, HIV and other sexually transmitted infections (STIs) are occurring more and more in this area. We discuss this with all of our clients, so we can make sure that everyone gets the information and services that best meet their needs. And, if it is not relevant to you personally, you may be able to share this information with someone else who needs it."</p>
<p><b>What is shared in counseling should be confidential</b>. Explain your facility's confidentiality policy (if applicable) to the client. If your facility does not have a confidentiality policy, the general standard in counseling is that you share the client's information only with other health staff and only when necessary (e.g., for a second opinion from a colleague). Note that confidentiality is meaningless if other people can hear what you are discussing with the client, and that ensuring privacy is the first step for maintaining confidentiality.</p>	<p>"I want you to know that what you share with me will stay with me only. If I need to ask another staff member about something, I will ask you if that is okay."</p>
<p><b>The client does not have to answer all questions</b>. If the client is not comfortable answering a particular question, he or she has the right not to answer.</p>	<p>"If there are any particular questions you do not feel comfortable answering, feel free to let me know and be aware that you do not have to answer all questions."</p>

Note: Adapted from: EngenderHealth, 2003f.

## Session 19

# The Risk Continuum

By the end of this session, you should be able to:

- Identify risk for pregnancy, transmission of HIV, and transmission of other STIs for various practices
- Explain how one behavior can be high-risk for one condition and low-risk for another
- Identify ways to lower the risk for some behaviors
- Explain in simple terms which behaviors put people at risk for pregnancy, HIV, and other STIs

### *Essential Ideas—Session 19*

- The risk for pregnancy and for transmission of HIV or STIs depends not only on sexual practices, but also on factors such as the difficulty of knowing a partner's sexual history, current practices with other people, and infection status.
- Behaviors that may be low-risk in one relationship could be high-risk in another. For example, a "typically" high-risk behavior such as anal sex would carry no risk at all for HIV or STI transmission if neither partner were infected; it also carries no risk for pregnancy. This makes the concept of risk confusing to providers as well as to clients.
- As a result of this confusion, it is especially important in counseling to use simple explanations to help clients better understand the risk for pregnancy and infection with HIV or an STI. Here are some examples:
  - Risk for pregnancy: any behavior that allows the man's semen to enter the woman's vagina
  - Risk for STI: any behavior (not just sexual) that allows contact between the infected area of one person and another person
  - Risk for HIV: any behavior (such as sexual contact, blood contact, and mother-child contact) that exposes one person to the body fluids (blood, semen, vaginal fluid, or breast milk) of an infected person
- It may not be possible to eliminate risk altogether, but risk *reduction* can have a significant positive impact on the client's health. This is why we think of risk as a *continuum*, in which clients can be encouraged to consider behaviors that are in a lower-risk category, even if that behavior is not entirely risk-free.

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## Discussion Summary

### ***Relationship Factors for Risk***

How does an individual's role in a sexual relationship and the context of the relationship affect risk? (In other words, how is risk affected if one partner has more power, or if one person has other partners, or if one person engages in some specific behavior with the other?)

- If one person in the relationship has less power, he or she may not be able to negotiate risk reduction with a partner, whether for pregnancy, HIV, or STIs.
- The “receptive” partner in vaginal and anal sex is usually at higher risk for HIV or STIs than the “giver,” and the partner who performs oral sex is at higher risk than the partner who receives it.
- If one or both partners in a relationship have other sexual partners, their risk for HIV or STIs increases.

### ***Biological Factors for Risk for HIV and STIs***

What are some biological factors that may increase the risk for HIV and STI transmission, either through some sexual acts or through mother-to-child transmission?

- Persons with open sores, lesions, or abrasions on the vagina, mouth, anus, or penis are at higher risk for HIV or STI infection if they are exposed during unprotected sex. (*Note:* “Exposed” means having had sexual intercourse—vaginal, oral, or anal—with someone who has HIV or an STI; “unprotected sex” means having had vaginal, oral, or anal sex without using either a male or female condom.)
- The tissue lining the rectum is very susceptible to microlesions and tears during anal sex, thus creating entry points for HIV and other STIs to enter the bloodstream if sex is unprotected.
- Adolescent girls whose vaginal tissue is not fully matured can develop microlesions during intercourse and are thus at higher risk of becoming infected with HIV and other STIs when exposed during unprotected sex.
- Someone with an STI, particularly an ulcerative STI such as syphilis or chancroid, is more likely to become infected with HIV if exposed.
- Men who are uncircumcised are more likely to become infected with HIV if exposed during unprotected vaginal sex than are men who are circumcised.
- A person with advanced HIV disease or AIDS has a higher viral load and is thus more likely to pass the infection on during unprotected sex than an HIV-positive person who is healthy.
- An HIV-infected pregnant woman who is healthy and well-nourished, and who thus has a lower viral load, is less likely to transmit the virus to her baby during pregnancy, labor, or breastfeeding.
- An HIV-infected breastfeeding mother is more likely to transmit the virus to her baby while breastfeeding if she has cracked and bleeding nipples (as a result of mastitis, breast abscess, or nipple fissure).

### Risk Continuum for Pregnancy, HIV, and Other STIs

	No risk	Low risk	Medium risk	High risk
<b>Pregnancy</b>	<ul style="list-style-type: none"> <li>• Abstinence</li> <li>• Masturbation</li> <li>• Oral sex on a man</li> <li>• Oral sex on a woman</li> <li>• Deep (tongue) kissing</li> <li>• Anal sex using a condom</li> <li>• Anal sex without using a condom</li> </ul>	<ul style="list-style-type: none"> <li>• Vaginal sex using a condom</li> <li>• Rubbing genitals together without penetration, unclothed</li> <li>• Vaginal sex with multiple partners, always using a condom</li> </ul>		<ul style="list-style-type: none"> <li>• Unprotected vaginal sex with your spouse</li> <li>• Unprotected vaginal sex with a monogamous, uninfected partner</li> </ul>
<b>HIV</b>	<ul style="list-style-type: none"> <li>• Abstinence</li> <li>• Masturbation</li> <li>• Sitting on a public toilet seat</li> <li>• Unprotected vaginal sex with a monogamous, uninfected partner</li> </ul>	<ul style="list-style-type: none"> <li>• Vaginal sex using a condom</li> <li>• Deep (tongue) kissing</li> <li>• Rubbing genitals together without penetration, unclothed</li> <li>• Vaginal sex with multiple partners, always using a condom</li> </ul>	<ul style="list-style-type: none"> <li>• Anal sex using a condom</li> <li>• Oral sex on a man</li> <li>• Oral sex on a woman</li> </ul>	<ul style="list-style-type: none"> <li>• Anal sex without using a condom</li> <li>• Unprotected vaginal sex with your spouse</li> </ul>
<b>Other STIs</b>	<ul style="list-style-type: none"> <li>• Abstinence</li> <li>• Masturbation</li> <li>• Sitting on a public toilet seat</li> <li>• Unprotected vaginal sex with a monogamous, uninfected partner</li> </ul>	<ul style="list-style-type: none"> <li>• Deep (tongue) kissing</li> <li>• Vaginal sex with multiple partners, always using a condom</li> </ul>		<ul style="list-style-type: none"> <li>• Oral sex on a man</li> <li>• Oral sex on a woman</li> <li>• Vaginal sex using a condom</li> <li>• Anal sex using a condom</li> <li>• Anal sex without using a condom</li> <li>• Unprotected vaginal sex with your spouse</li> <li>• Rubbing genitals together without penetration, unclothed</li> </ul>

*Note:* This continuum can change depending on social and individual factors, such as involvement with other partners (for HIV and STI risk) or whether the woman is in her fertile time (for pregnancy risk), among others.

## Session 20

# Exploring the Context of Clients' Sexual Relationships

By the end of this session, you should be able to:

- Explain why you need to ask questions about clients' sexual relationships
- List at least three questions that you can use to help clients explore their sexual lives, including social context and the circumstances under which they have sexual intercourse

### *Essential Ideas—Session 20*

- To help clients accurately perceive where they are on the "risk continuum," you need to ask questions to determine what kind of sexual relationships and behaviors clients are experiencing.
- For most providers, asking questions about a client's sexual relationships is one of the most difficult parts of counseling. It helps to think in advance about what questions you can ask, to make both yourself and your clients feel comfortable, while still gathering the personal and sensitive information necessary to help clients accurately assess their own risk level. These questions may change from client to client and over time, as you yourself become more comfortable with this process or as the community becomes more aware of the need to discuss such issues with providers.

### Participant Worksheet

*Note:* This worksheet is for writing some of the questions that were developed in small-group work for this session. You can, of course, add your own ideas for questions that you would be more comfortable asking your clients.

#### Sample Questions to Explore the Context of a Client's Sexual Relationships

Questions from the REDI framework	Questions you could ask your clients
<ul style="list-style-type: none"> <li>• What sexual relationships are you in?</li> <li>• What is the nature of your relationship (including violence or abuse)?</li> <li>• How do you feel about it?</li> </ul>	
<ul style="list-style-type: none"> <li>• How do you communicate with your partner about sexuality, family planning, and HIV and STIs?</li> </ul>	
<ul style="list-style-type: none"> <li>• What do you know about your partner's sexual behavior outside of your relationship?</li> </ul>	

## Session 21 Information-Giving in Integrated SRH Counseling

By the end of this session, you should be able to:

- Identify basic information that clients need about SRH, regardless of the service that they request

### *Essential Ideas—Session 21*

- Providing “integrated” SRH counseling reflects the fact that one’s sexual and reproductive life is *not* separated into unrelated units of contraception, disease prevention and treatment, reproduction, and experience with intimacy and pleasure. For individuals and couples, all of these elements are woven together into sexual and social relationships, interactions, and consequences—personal, medical, and social. Since these issues are integrated in the client’s life, it makes sense to provide information about them in an integrated manner when clients seek SRH services.
- In an *integrated* approach, we attempt to identify these issues in a comprehensive assessment of the individual’s SRH status and need for information, regardless of the reason for the visit. In many cases, subsequent visits will have to be scheduled or referrals will have to be made to other service sites or to other services within the same site. The most important thing, though, is that the client’s needs have been identified and addressed in some concrete, comprehensive way.
- There are key “facts” about each area of SRH that every client should know, regardless of the reason for their visit. The purpose of this session is to identify those key facts and help you practice explaining them to clients.

## Key Messages in Integrated SRH Counseling

What do clients need to know in these areas?			
<p><b>Family planning</b></p> <ul style="list-style-type: none"> <li>• Benefits of family planning</li> <li>• What family planning methods are available</li> </ul> <p>For methods of interest:</p> <ul style="list-style-type: none"> <li>• Effectiveness</li> <li>• Side effects and complications</li> <li>• Advantages and disadvantages</li> <li>• How to use</li> <li>• HIV/STI prevention</li> <li>• When to return</li> </ul> <p>For specific information on each method, see: Appendix A.</p>	<p><b>HIV/STIs</b></p> <p>For all clients:</p> <ul style="list-style-type: none"> <li>• Transmission of HIV/STIs</li> <li>• Prevention of HIV/STIs</li> <li>• Safer sex</li> <li>• Assessment of client's own level of risk</li> <li>• Signs and symptoms of HIV/STIs</li> </ul> <p>Basic health education messages for STI clients (the 4 Cs):</p> <ul style="list-style-type: none"> <li>• Compliance with treatment</li> <li>• Counseling for prevention</li> <li>• Condoms</li> <li>• Contact tracing and treatment</li> </ul> <p>For specific information on HIV and STIs, see: Appendix D.</p>	<p><b>Pregnancy-related care</b></p> <p>Antenatal care</p> <ul style="list-style-type: none"> <li>• Diet during pregnancy</li> <li>• Rest and activities</li> <li>• Personal hygiene</li> <li>• Immunization</li> <li>• Danger signs of pregnancy</li> <li>• Contraception after delivery</li> </ul> <p>Messages for family</p> <ul style="list-style-type: none"> <li>• Preparation for delivery</li> <li>• Access to emergency obstetric care</li> </ul> <p>Postpartum care</p> <ul style="list-style-type: none"> <li>• Diet and supplementary food</li> <li>• Rest and activities</li> <li>• Personal hygiene</li> <li>• Breastfeeding</li> <li>• Immunizations for newborn</li> <li>• Postpartum danger signs</li> <li>• Contraception</li> </ul> <p>For specific information on postpartum care, see: Appendix C.</p> <p>Postabortion care</p> <ul style="list-style-type: none"> <li>• Explanation of what is happening to her body</li> <li>• What to expect during the procedure</li> <li>• Possible side effects and complications</li> <li>• How to take care of herself during recovery</li> <li>• Return to fertility (11 days after procedure)</li> <li>• Use of family planning to prevent or delay future pregnancies</li> <li>• Risk of HIV/STIs, with referral if needed</li> <li>• Referral for other services, if needed</li> </ul> <p>For specific information on postabortion care, see: Appendix B.</p>	<p><b>Other considerations</b></p> <ul style="list-style-type: none"> <li>• Adolescent sexuality</li> <li>• Women's sexuality concerns</li> <li>• Men's SRH concerns</li> <li>• Infertility</li> <li>• Menopause</li> <li>• Reproductive tract cancers</li> <li>• Breast cancer</li> <li>• Gender-based violence</li> <li>• Female genital cutting</li> </ul>

Which of these areas do you need to cover with your client?

## Session 22

### Risk Assessment— Improving Clients' Perception of Risk

By the end of this session, you should be able to:

- Define *risk assessment* and explain why and how it is used in counseling
- Identify three reasons why it is difficult for people to perceive their own risks
- Describe two ways in which they can help clients perceive and understand their own risks for HIV and STI transmission and for unintended pregnancy

#### *Essential Ideas—Session 22*

- Risk assessment is a counseling process to help clients understand the risk associated with sexual practices that they or their partners are engaging in, and how this level of risk may change depending on changes in their circumstances.
- We help clients to assess their own risk so they can use this understanding to reduce their risk, with a focus on behavior change. This is an ongoing process that begins with the exploration stage and continues through decision making and planning to implement the decision.
- In counseling, we must respect that people have different understandings about what risk means in their life. For a variety of reasons, people tend to underestimate their risk and perceive themselves to be at less risk than they actually are. Given this reality, providers need to develop skills to help clients perceive and understand their risks.
- Self-perception of risk is an essential step in behavior change. People who perceive themselves to be at risk will be more motivated to make changes to protect themselves from unintended pregnancy or from the transmission of HIV and STIs than will people who do not see themselves as being at risk.
- You can help clients to better perceive and acknowledge their own risks by relating risk to the client's individual circumstances and by using examples of how the client may have protected his or her health by reducing risk in other areas.

## Session 22

### Risk Assessment

#### ***What is it?***

Risk assessment is a counseling process to help clients understand the risk (i.e., the chance of getting pregnant or becoming infected) that is associated with sexual practices in which they or their partners are engaging, and how this level of risk may increase or decrease depending on changes in circumstances. For example, your risk could *increase* if:

- Your uninfected partner becomes infected
- You had one partner and now you have more than one
- You have a new partner and you do not know his or her sexual history
- Your partner changes his or her mind and decides that he or she does not want to use condoms
- You develop side effects to a contraceptive method and discontinue its use

#### ***Why do we do it?***

We help clients assess their own risk so they can use this understanding to reduce their risk, with a focus on behavior change.

#### ***How do we use it in REDI?***

##### *Exploration*

We use exploration as a guide for asking questions, to learn about clients' relationships and sexual behaviors and other factors that may put them at risk, and for providing information that clients will need to make a decision about reducing risk.

##### *Decision making*

We use decision making to help clients choose behaviors, family planning methods, or medical treatments that will reduce their risk.

##### *Implementing the decision*

We use implementation to help clients make a plan for how they will change behaviors, how they will communicate with partners, how they will cope with the problems or challenges they might encounter, and how they will deal with changes in their life circumstances.

### Barriers to Clients' Perception of Risk

Whether the client *perceives* that he or she is actually at risk for unintended pregnancy or HIV and STI infection is a crucial starting point in helping the client to be willing to take some steps toward reducing risk. In many cases, people perceive themselves to be at less risk than they actually are. People have many reasons for underestimating their own risk.

#### **Some reasons why people underestimate their risk include:**

- **Stereotyped beliefs about who is at risk.** Many people still mistakenly believe that truck drivers, migrant workers, homosexuals, sex workers, and intravenous drug users are the only people who are at risk for HIV. They think that just because they are in a heterosexual relationship, they are safe from risk—or that because they are in a marriage or monogamous relationship, they can trust that their partner will not have any other partners. For many women, in particular, messages about “being faithful” may give a false sense of safety,

since they are most often at risk due to the behavior of their partners rather than their own behavior.

- **The illusion of invulnerability.** Some people may have a personal belief that they are immune to risk regardless of their behaviors. People generally tend to underestimate their own personal risk in comparison to the risk faced by others who are engaging in the very same behaviors. An example would be an adolescent girl who thinks she will not get pregnant even if she has sex without using a method of family planning: “It will not happen to me.” Adolescents, in particular, as part of their emotional development, often think of themselves as invulnerable to many things.
- **Fatalism.** Fatalism is a belief that circumstances are beyond one’s control: Nothing a person does will change what is going to happen anyway. An example of this would be a person who believes that spiritual forces determine how many children you will have, and that therefore it is not necessary to use family planning.
- **Bigger or more urgent problems.** A person may have other concerns that need immediate attention and that put the threat of HIV and STIs or unintended pregnancy into the background. People who live in communities where hunger, violence, or poverty is widespread, for example, are more likely to prioritize other issues, such as feeding and protecting their children from harm.
- **Misconceptions about risk.** Mistaken beliefs may interfere with a person’s understanding of what *is* actually risky. For example, a person might not have a clear understanding of how HIV is spread (i.e., they might believe that HIV can be transmitted through contact with toilet seats, or through the sharing of eating utensils, etc.). Another example would be a young woman who mistakenly believes that she cannot get pregnant the first time she has sex.
- **Traditional gender roles and societal expectations.** Different societal expectations and social norms often influence clients’ behavior. For example, a woman might suspect that her husband is having extramarital relationships, but it may not be acceptable within her social or cultural role to bring this to his attention. Therefore, it is easier for her to not acknowledge or to minimize the potential risk, when there is little or nothing she feels she can do about it.

*Note:* Adapted from: STD/HIV Prevention Training Center, 1998.

## Discussion Summary

### Why is a client’s perception of his or her own risk so important?

- Most people will not be able to make a behavior change unless they perceive that they are at risk. If a client does not perceive sufficient risk, then he or she will not be motivated to make health-related changes.
- In most cases people need to feel “ownership” of a plan to change behavior if they are to carry it out. If the provider simply tells the client what to do without working together to develop a plan that is both meaningful and realistic for the client, it is unlikely that the client will follow it.

### What are some of the ways in which providers can help clients to perceive and understand their own risks?

- Ask the client to relate risks to the specifics of his or her circumstances. For example, if a client acknowledges that her husband has other partners and does not use condoms, highlight

## Session 22

that particular risk to her. To make it less threatening, you might say that “many women find themselves in similar situations.”

- Try to personalize clients’ risk by providing information that is specific to the client. For example, if an adolescent girl does not wish to get pregnant but is not using contraception, you could provide her with brochures or comic-style booklets specifically designed for adolescents that discuss the risks and realities of adolescent pregnancy.
- Try to look for ways that clients have protected their health in the past and draw their attention to these successes. For example, if a client has used the pill to prevent unintended pregnancy, acknowledge that she perceived a risk of getting pregnant and took positive action to prevent the risk. Gently suggest that there may be other health risks that she might address as well. For example, if her partner recently was treated for an STI, point out that any sex partner of a person with an STI is at risk.

*Note:* Adapted from: STD/HIV Prevention Training Center, 1998.

## Session 23

### Counseling Practice I

By the end of this session, you should be able to:

- Demonstrate the Rapport-building step of REDI (or the Greet step of GATHER)
- Demonstrate how to use open-ended questions to explore the client's needs, risks, sexual life, social context, and circumstances (REDI: Exploration, Step 1; or GATHER: Assess)
- Demonstrate how to assess the client's knowledge and to give information to fill gaps, as needed (REDI: Exploration, Step 2; or GATHER: Assess and Tell)
- Demonstrate how to help the client to perceive his or her own risk for HIV and STI transmission or unintended pregnancy (REDI: Exploration, Step 3; or GATHER: Assess and Tell)

#### *Essential Ideas—Session 23*

- This session allows you to demonstrate the attitudes necessary for integrated SRH counseling, and to practice the skills and apply the knowledge that you have gained so far in this course.
- It is important to recognize that new skills can be mastered *only* through practice, and that proficiency comes with experience. Thus, these practice sessions are an important first step in that process.

## Part V

# Assisting Clients in Making Their Own Voluntary and Informed Decisions

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Assisting clients in making voluntary and informed decisions sometimes may be a matter of confirming a decision that the client made before he or she even entered the clinic and sometimes may involve helping the client weigh several options to reach his or her decision. While a provider's objective may be to help individuals make their decision, often the decision-making process is heavily influenced by gender expectations in the client's social setting or by power imbalances in personal relationships that may limit the client's decision-making capacity. Counseling can and should address all of these factors.

## Session 24 Gender Roles

By the end of this session, you should be able to:

- Define *gender* and *gender roles*
- Describe how gender roles can affect communication between SRH clients and providers and between clients and their partners
- Describe how gender roles can have a negative impact on SRH

### *Essential Ideas—Session 24*

- **Gender** is how an individual or society defines “male” or “female.”
- **Gender roles** are socially or culturally defined attitudes, behaviors, expectations, and responsibilities that are considered appropriate for women and men. Gender roles may vary according to culture, class, and ethnicity.
- Gender roles can affect communications about SRH both between clients and their partners and between clients and providers.
- Gender roles may limit women’s ability to gain access to information and services and their ability to make their own decisions about their sexual and reproductive health. In addition, gender roles may limit a woman’s control over when and with whom she has sexual intercourse or whether she is protected against pregnancy or STIs.
- Gender roles can also have a negative impact on men, by making them reluctant to ask questions about sexuality and show that they do not know everything. A man may also be limited in his access to information and services that are considered to be “only for women.” Also, gender roles that put pressure on a man to be sexually experienced can lead to his being exposed to infection and causing unintended pregnancy.
- Exploring your own sense of gender roles, and how you learned them, is useful for helping you become more sensitive to assumptions that you make about clients and to the impact of your own gender on your communications with clients.

## Session 25

# The Effect of Power Imbalances on SRH Decision Making

By the end of this session, you should be able to:

- Identify four categories of behavior that people use to control their partners in different types of sexual relationships
- Describe how such behaviors can affect the ability of partners to make and carry out decisions regarding SRH
- Explain the concept of social vulnerability to HIV and STIs or to unintended pregnancy

### *Essential Ideas—Session 25*

- When we think of “power” or “power imbalances” in relationships, we may think of physical force. However, physical force, or abuse, is not the only type of controlling behavior that people experience in relationships. Such behavior comes in many forms—emotional or psychological, financial, and sexual—and can be just as damaging as or even more damaging than physical abuse. Many people who are not physically abused do not even realize that they are being abused.
- Consideration of power or power imbalances in relationships usually leads to thoughts of men using their power to control women. This is not always the case. However, in many cultures, “normal” gender relations and a lack of power in sexual decision making prevent women from protecting themselves from HIV or STIs and unintended pregnancy, even if they are aware that their partner’s behavior is putting them at risk. Because of their social and economic dependence on men, women frequently have little power to refuse sex or to insist on the use of barrier methods, such as condoms. This session focuses on such gender-related power imbalances, since they are more common.
- Factors that contribute to “social vulnerability” to HIV or STIs and unintended pregnancy include gender, economic power, youth, stigmatization of some groups in society, and government policies that create barriers to SRH information and services for women and youth.

Examples of Behaviors Used to Control a Partner

<p><b>Physical</b></p> <ul style="list-style-type: none"> <li>• Hitting</li> <li>• Kicking</li> <li>• Biting</li> <li>• Punching</li> <li>• Choking</li> <li>• Restraining</li> <li>• Pushing</li> <li>• Pulling hair</li> <li>• Burning</li> <li>• Cornering a person and not letting him or her enter or leave a room</li> <li>• Throwing objects at a person</li> <li>• Cutting</li> <li>• Not allowing a person to go to the doctor</li> <li>• Preventing a person from taking medication</li> </ul>	<p><b>Emotional/psychological</b></p> <ul style="list-style-type: none"> <li>• Criticizing a person constantly, especially in front of other people</li> <li>• Calling a person names</li> <li>• Questioning a person's intelligence</li> <li>• Accusing a person of being a bad parent, cook, or lover</li> <li>• Criticizing a person's appearance</li> <li>• Threatening to hurt a person or his or her children</li> <li>• Following a person around town</li> <li>• Accusing a person of infidelity</li> <li>• Threatening to destroy a person's property</li> <li>• Not allowing a person to sleep at night</li> <li>• Threatening a person with weapons without using them</li> <li>• Threatening to leave the relationship</li> <li>• Sending a person out to run an errand and timing her departure and return</li> </ul>
<p><b>Financial</b></p> <ul style="list-style-type: none"> <li>• Not allowing a person to own anything in his or her own name</li> <li>• Not allowing a person to handle money or make decisions about spending</li> <li>• Stealing money that a person had from his or her family or from working</li> <li>• Preventing a person from working</li> <li>• Not allowing a person to attend or to finish school</li> <li>• Forcing a person to work several jobs</li> </ul>	<p><b>Sexual</b></p> <ul style="list-style-type: none"> <li>• Rape</li> <li>• Forcing a person to do something sexual that he or she does not want to do</li> <li>• Forcing a person to have sex with another person in front of his or her partner</li> <li>• Forcing a person to have sex for money</li> <li>• Forcing a person to view pornographic material</li> <li>• Criticizing a person's sexual performance</li> </ul>

Adapted from: EngenderHealth, 2002.

## Social Vulnerabilities and HIV and STI Risk

Some factors that affect social vulnerability are:

- Gender
- Economic power
- Youth
- Culture
- Policies (for example, those related to the illegal status of sex work, condom availability, sex education, and laws regarding homosexuality, among others)

### **Why Are Women More Vulnerable than Men to HIV and STI Infection?**

#### *Biologically*

- They have a larger mucosal surface in the vagina; microlesions that can occur in the vagina during intercourse may be entry points for the virus; very young women are even more vulnerable in this respect.
- Viral concentration is higher in sperm than in vaginal secretions.
- As with STIs, women are at least four times more vulnerable to infection; the presence of untreated STIs is a risk factor for HIV.
- Coerced sex increases risk of microlesions, due to the lack of vaginal lubrication.

#### *Economically*

- Financial or material dependence on men means that women cannot control when, with whom, and under what circumstances they have sex.
- Many women have to exchange sex for material favors, for daily survival. In addition to formal sex work, there is also this type of exchange, which in poor settings may represent many women's only way of providing for themselves and for their children.

#### *Socially and culturally*

- Women are not expected to discuss or make decisions about sexuality.
- Women cannot request (or insist on) use of a condom or any form of protection.
- If women refuse sex or request condom use, they often risk abuse, as there is a suspicion of infidelity.
- The many forms of violence against women mean that sex is often coerced, which is itself a risk factor for HIV infection.
- Women are sometimes expected to have relations with or marry older men, who are more sexually experienced and are thus more likely to be infected. In some places, men seek younger and younger partners so as to avoid infection or in the belief that sex with a virgin cures AIDS and other diseases.

*Note:* This section was adapted from: WHO, 2000.

## Session 25

### ***Why Are Young People More Vulnerable to HIV and STI Infection?***

- Younger people, especially children and adolescents, tend to have less power to resist the demands of an older person.
- Younger people may be coerced into sexual behavior with older people through manipulation or threats (e.g., “I will tell your family that you wanted it”).
- Because older people (particularly men) tend to be more sexually experienced, they are more likely to have been exposed to HIV or STIs and therefore are more likely to pass them on to the younger person (e.g., in many countries, older men seek younger women as sex partners, and therefore women become infected with HIV at much younger ages than do men).

### ***What Policies Make People More Vulnerable to HIV and STI Infection?***

- If governments make certain practices or behaviors illegal (such as commercial sex work or sex between people of the same sex), this may place people at greater risk if they do not have access to information on how to protect themselves and are afraid to seek health care.
- Government policies that limit women’s access to education, property, money, and other resources may make women more vulnerable to HIV and STI infection because they must depend on men, giving them less power to negotiate safer sex.
- Government policies that restrict sex education (including information on HIV and STI prevention) in public schools keep younger people unaware of their risks and ignorant about how to protect themselves from infection with HIV or STIs and from unintended pregnancy.

## Participant Worksheet

### Case Studies on Power Imbalances in SRH Decision Making

(Note: A sample answer for each case study is found on pages 115 and 116.)

#### Case Study 1

Susheela is a 15-year-old secondary school student. Her family is very poor and often does not have enough money to pay for school fees, books, and uniforms. Lately, Ramesh, a 35-year-old small-business owner, has been paying special attention to Susheela. He has offered her rides in his car and taken her out for meals. Ramesh is married and has two young children. Ramesh tells Susheela that if she is his "special friend," he will give her money to pay for school expenses, so Susheela has sex with Ramesh. Ramesh is the first person that Susheela has had sex with. She has never discussed sexuality or contraception with her family, nor has she been offered sex education in school. Ramesh tells her not to worry about getting pregnant, because he will make sure it does not happen. He also makes fun of condoms, saying that real men would never use them. Susheela never knows in advance when she will see Ramesh. When Ramesh does find Susheela, he picks her up in his car and takes her to a remote area for sex. When the sex is over, Ramesh tells Susheela he will give her some money for school only if she promises not to tell anyone about what they have just done. He also threatens to hurt her if anyone finds out.

- What factors contribute to Susheela's vulnerability to unintended pregnancy and infection?
- If you were counseling Susheela, what strategies would you recommend to enable her to protect herself against pregnancy and infection?

*(continued)*

**Note to participants:** Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.

**Participant Worksheet****Case Studies on Power Imbalances in SRH Decision Making (continued)****Case Study 2**

Rosa is 25 and married to Carlos; they have four children. Rosa married at age 16 and never completed her education. In the past year, there have been strains on their marriage. Carlos maintains strict control over the household money, yet he has not been able to find steady employment as a laborer. When there is work, Carlos seems happy to provide for the family, but when he is out of work, he spends what little money there is on alcohol and, as Rosa suspects, on other women. When Carlos is out of work, he often comes home drunk and demands sex from Rosa. Rosa complies with his demands even when she does not feel like having sex, because she believes that it is her obligation as a wife. She has been to a health clinic to get a method of contraception. Carlos agreed that it would be a good idea for her to use the pill. About six months ago, when she went for a follow-up visit, the clinic doctor noticed an unusual vaginal discharge and diagnosed Rosa with an STI. She took medicine to treat it but did not tell Carlos, for fear of his reaction. She knows that she must have gotten it from Carlos. Rosa has heard that condoms can prevent STIs, but she knows that Carlos would never use one. In fact, if she asked him to, she fears that he might even leave her, as he has threatened to do before. While they have their problems, Rosa loves Carlos. He is a good father, especially when he is working. If he left, she does not know how she and the children would survive.

- What factors contribute to Rosa's vulnerability to infection?
- If you were counseling Rosa, what strategies would you recommend to enable her to protect herself against infection?

*(continued)*

**Participant Worksheet****Case Studies on Power Imbalances in SRH Decision Making (continued)****Case Study 3**

Zanela is 30 years old, a mother of three children, and a widow from a very poor country. Her husband recently died in a mining accident. She sells vegetables in the market but makes barely enough to feed her children and maintain the household. To supplement her income, she has begun to go out on the road at night to have sex for money with the truck drivers who come through her village. She has some condoms that she got from a clinic once and sometimes she asks the men to use them. Some men do, but others offer her more money for not using a condom. Given her financial situation, she accepts additional money and forgoes condom use. As far as she is concerned, feeding her children right now is her immediate concern, and this priority is much more important than insisting on condom use to prevent the possibility that she could get pregnant or contract HIV or some other STI.

- What factors contribute to Zanela's vulnerability to unintended pregnancy and infection?
- If you were counseling Zanela, what strategies would you recommend to enable her to protect herself against unintended pregnancy and infection?

*(continued)*

**Participant Worksheet**

**Case Studies on Power Imbalances in SRH Decision Making (continued)**

**Case Study 4**

Christopher is a 28-year-old man living in a big city. He is married to Virginia, who is 24, and they have three young children. Christopher loves his family and is a good father and a good provider, and he works hard to give his children a better chance for a good education and a better future. As long as he can remember, Christopher has always felt a sexual attraction for other men, but he has had to hide it all of his life because he knows that this is not accepted in his culture. Christopher knows that there are lots of other men like him, and most of them get married and live a second life like he does. Christopher does not have a regular male sexual partner, because he is too afraid that people might find out, so he goes to several places where men meet other men to have casual sex. None of the men use condoms. Christopher, like most people in his community, has heard about HIV and STIs. He knows that the local health center has information about HIV and STIs, but the people there seem to be concerned with women, and he feels that it would look strange if he were to go there. In addition, he fears that the health practitioners would find out about his having sex with other men and would shame him and tell other people in the community. Meanwhile, Christopher continues to have unprotected sex with Virginia, and she does not suspect anything.

- What factors contribute to Christopher's vulnerability to infection and risk of transmitting the infection to his wife?
- If you were counseling Christopher, what strategies would you recommend to enable him to protect himself (and his partners) against infection and his wife against unintended pregnancy?

*(continued)*

## Participant Worksheet

### Case Studies on Power Imbalances in SRH Decision Making *(continued)*

#### *Sample answer for Case Study 1:*

Susheela is at risk for a variety of reasons. Her poverty makes her vulnerable to exchanging sex for money and supplies for school. The age disparity between Susheela and Ramesh makes her vulnerable, because she may have been taught to "show respect" and trust for older people. Her young age places her at risk biologically, because her vaginal tissues are less mature and more likely to tear, making it easier for infection to occur. Her lack of knowledge related to sexuality, contraception, and infection places her at risk, because she is unable to perceive her own risk and unequipped to protect herself. Cultural taboos against discussing issues related to sexuality at home or in school perpetuate myths about STIs that increase her risk. The gender-related factors include Ramesh's refusal to use condoms because "real men" do not wear them, which stems from societal attitudes about masculinity. Socialization for women to be compliant and submissive about sex and for men to be aggressive and in control about sex affects the dynamic between Susheela and Ramesh. His threat of violence and control of economic resources are also related to gender roles.

#### *Sample answer for Case Study 2:*

Many factors place Rosa at risk of infection. Carlos and Rosa are in an unequal relationship, with Carlos controlling the resources, determining the nature and timing of their sexual activity, and threatening to leave if Rosa defies him. Prevailing attitudes about masculinity and femininity perpetuate a situation in which Carlos demands sex from Rosa and she feels that she must comply, even when she does not want to. Other attitudes about gender roles have influenced this situation, such as expectations that men be "good providers," expectations that men have multiple sex partners, the notion that drinking makes men "manly," and the idea that it is a wife's obligation to provide sex whenever her husband wants it.

Given that Rosa has already experienced one STI, she is at risk of reinfection or infection with another STI, especially because Carlos was not treated. The fact that there are positive elements in their relationship further complicates the situation, because Rosa is even more willing to place herself in risky situations for the "good of the relationship." However, this also shows that Rosa may be able to talk with Carlos about the STI, if she can choose a good time. Despite all of the factors against her, Rosa has had the insight and means to visit a family planning clinic and is aware that condoms could protect her. She would greatly benefit from counseling to help her develop a risk-reduction plan and to build skills to follow it through.

#### *Sample answer for Case Study 3:*

The primary risk for Zanela is her poverty and her status as a single mother struggling to provide for her children. Because she is from a poor country, the government has not prioritized pensions or financial subsidies for widows. Because she is poor, she needs to supplement her income through sex work. Poverty places her at additional risk when she is offered extra money to forgo condom use. When she has sex with truck drivers, they have the financial resources to influence the nature of their sexual activity (i.e., whether to use condoms). Despite these factors against her, Zanela has obtained condoms and has asked clients to use them. She could benefit from counseling and support to insist on condom use at all times.

*(continued)*

## Participant Worksheet

### Case Studies on Power Imbalances in SRH Decision Making *(continued)*

#### *Sample answer for Case Study 4:*

The fear of becoming an outcast and of shaming his family is a very powerful force that places Christopher in a vulnerable situation. He and the other men who are leading “double lives” are at risk because the denial and secrecy surrounding their sexual relationships makes it difficult for them to acknowledge their risk and to take steps to protect themselves. Christopher perceives the local health center as a place that is not equipped to respond to the needs of men like him. His fear of disclosing his sexuality may be based on the assumption that the staff at the center probably share the same views as the rest of the community on men who have sex with other men. He feels that seeking help there would only worsen his situation, and this increases his isolation and further undermines his ability to seek help and to discover ways to protect himself and others. Christopher continues to have unprotected sex with Virginia, so she too may be at increased risk of infection. Christopher’s children are also affected by the situation, because their future would be in jeopardy if one or both of their parents became ill.

## Session 26

# Helping Clients Make Decisions— Counseling Practice II

By the end of this session, you should be able to:

- Identify the steps in the decision-making phase of integrated SRH counseling (REDI—Phase 3, Decision making; GATHER: Help)
- List at least one open-ended question to ask clients for each of the four steps
- Describe the role of the provider in helping the client to make his or her own informed decisions and in supporting the client's sexual and reproductive rights
- Demonstrate helping a client to make his or her own decision

### *Essential Ideas—Session 26*

- In the decision-making phase of integrated SRH counseling, the provider helps the client to:
  - Focus on the key decisions he or she needs to make
  - Identify options
  - Weigh the benefits, disadvantages, and consequences of each option
  - Reach his or her own decision
- The decision-making phase of counseling is key to supporting the rights of individuals to make their own decisions regarding SRH, without pressure or coercion. One role of the provider is to determine if other people are trying to make the client do something that he or she does not want to do and to help the client reach his or her own decision.
- At the same time, the provider must be aware that he or she may be putting pressure on the client to make the decision that seems medically "correct." While the provider's medical opinion needs to be considered as a factor in the decision making, the client should feel that he or she has come to that choice for his or her own reasons.
- Power imbalances may exist between clients and providers, due to differences in education, social status, age, or gender. Providers need to be aware that their greater power can result in barriers to communication, as well as perceived pressure on decision making by the client.

*(continued)*

*Essential Ideas—Session 26 (continued)*

- Achieving the balance of helping a client to make a decision, without putting undue pressure on the client, has been a major challenge for providers. Providers typically either tell the client what to do or give information and leave the client on his or her own to figure out what to decide. The approach taken in this training is somewhere between those two extremes. An additional challenge is that every client will differ in terms of how much input and guidance they will need from the provider. This is why the “client-centered” approach—treating each client as an individual and basing your input on the client’s unique needs and concerns—is considered the best guidance for this step.

**Discussion Summary**

**Research has consistently shown that helping clients to make decisions is one of the weakest areas of counseling. Why might this be true?**

*Fear of “motivating”*—After years of promoting family planning methods or “motivating” clients to meet program targets, some providers have become reluctant to get involved in the client’s decision making. Instead, they give all of the information that they think the client needs and then let the client make his or her own choice, without questioning the client’s reasoning about the decision. The result is that clients may in fact be making their own “choices,” but it is hard to know how well-informed they are, if the provider does not clarify *how* or *why* the client reached that decision.

*Embarrassment about discussing sexual issues*—Decision making can be a very personal matter, particularly in areas of sexuality. Until recently, family planning providers have had little guidance for helping a client make decisions about reducing risk for HIV and STIs. Rather than embarrass themselves by asking questions about the client’s sexual behavior, in some situations providers have instead chosen to give information about HIV and STI risk and then let the client choose whether to use condoms, without questioning his or her choice.

*Time pressures*—Finally, busy providers are sometimes happy to see that a client arrives at the facility with a decision already made. Rather than take the time to explore whether the client is well-informed about the choice as well as about the alternatives and to find out if the client has been pressured in any way, they simply go ahead and provide the requested service.

*Respecting the clients’ preference*—In family planning, research has shown that clients who receive the contraceptive method that they wanted when they came to the clinic are more satisfied with their method and use it for longer than those who receive a different method. Providers may interpret this finding as a guidance to give the client what he or she wants, without checking the client’s awareness, knowledge, and reasons.

## Part VI

# Helping Clients Develop the Skills to Carry Out Their Decisions

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Making a decision about an SRH problem or need is only the first step toward the client's meeting his or her need. The client then must leave the clinic and carry out this decision on his or her own. Some decisions (for example, condom use) will require consistent action on the part of the client *and* partners. Other decisions (for example, to have a partner tested for STIs or HIV) require the client to influence someone else's behavior. These sessions examine ways in which the provider can help prepare a client to carry out his or her decision, including helping the client develop communication strategies and skills.

## Session 27

# Helping Clients Develop an Implementation Plan— Counseling Practice III

By the end of this session, you should be able to:

- Identify practical ways for helping clients make a plan to carry out their SRH decision
- List the skills that clients might need to develop to carry out their plan

### *Essential Ideas—Session 27*

- When a provider and a client work on a plan for carrying out a decision, the plan must come from the client. The provider's role is to help the client address key considerations, to be sure that the plan fits into the realities of the client's life and is one that he or she feels confident trying.
- Another important role of a provider is to help a client anticipate the consequences of his or her decision and implementation plan, and how he or she will deal with them.
- Any plans involving behavior change must be specific. This means that when a client says that he or she will take a particular step to change a behavior, you need to ask questions that will allow this client to say the specific steps out loud and think through the sequence.
- Skills that clients may need to develop if they are to implement their decisions include partner communication and negotiation skills, condom-use skills, and how to use other family planning methods.

## Helping Clients Make Implementation Plans

*Note:* This is a sample format for helping a client develop a plan to reduce risk. In most settings, it will not be feasible to fill out a form such as the one below. Rather, this form is provided for reference purposes only.

<p><b>Personal Information</b></p> <ul style="list-style-type: none"> <li><i>Client background information</i> Yashira, age 21, married. Arranged marriage. Three-month-old baby.  Came to clinic for IUD.  Husband, age 40, not working right now (seasonal laborer); drinks alcohol. Occasionally yells when he is drunk, but has never hit her or their baby.</li> <li><i>Social supports</i> Has one sister who lives in next village, a two-hour walk away; parents are dead. Has a close friend who lives nearby.</li> </ul>	<p><b>Client's Knowledge</b></p> <ul style="list-style-type: none"> <li><i>Knowledge of HIV and STI transmission</i> Believes that HIV is transmitted by promiscuous people, homosexuals, sex workers, and foreigners. Has heard that HIV and STIs can be spread by mosquito bites and by sharing cups and utensils. Believes that people with HIV look very thin and have a certain color to their eyes, and that people with STIs get very serious sores, their genitals dry up, and they can no longer have or make babies.</li> <li><i>Knowledge of family planning</i> Has heard of oral contraceptives, the IUD, condoms, and sterilization. Sister uses IUD and likes it.</li> </ul>
<p><b>Behavioral History</b></p> <ul style="list-style-type: none"> <li><i>Client sexual history and current sexual behaviors (including condom use)</i> Played kissing games as an adolescent; was a virgin when married. Has never used condoms. Husband was married before; suspects that he probably has other partners. Has no idea about his past or current condom use.</li> <li><i>Family planning history</i> Has never used a method of family planning. Not sure if her husband has.</li> </ul>	<p><b>Perceptions of Risk</b></p> <ul style="list-style-type: none"> <li><i>Perceived risk for HIV and STIs</i> Believes that it is possible her husband is at risk, but assumes that he will be able to tell which women do and do not have HIV and choose carefully.</li> <li><i>Perceived risk for unintended pregnancy</i> Stopped having sex with husband right after birth of baby. Now that the baby is three months old, her husband wants to have sex again. Afraid of a pregnancy too soon. Wants IUD.</li> <li><i>Perceived risk for other concerns (e.g., violence)</i> Worried about husband's drinking and potential for violence, especially when he is out of work.</li> </ul>

*To reduce my risk for HIV/STIs, pregnancy, and violence, I will:*

- Talk with my husband about using family planning and tell him that I would like to use the IUD to prevent pregnancy for a couple of years, until our baby is older.
- Tell my husband that the health care provider recommends also using condoms for dual protection against both unintended pregnancy and STIs.

- Talk with my husband about my spending the night at a friend's house the nights he goes out drinking because "I feel scared to be alone." (This will protect me if he comes home drunk and violent.)
- Bring home literature from the clinic on family planning and HIV and STI prevention so my husband can read the material and explain it to me. (This is a strategy to inform him without confronting him.)

***This plan will work if my husband:***

- Is willing to talk with me about family planning and HIV and STI prevention
- Allows me to spend the night at a friend's house when he goes out
- Agrees to our using a method of family planning to prevent pregnancy, plus condoms to prevent HIV and STIs (or condoms alone to do both)

***The people who will be able to help me with this plan include:***

- Provider
- Husband
- Myself
- Friend

***I will come back for a follow-up visit to see how well the plan is going on:***

- 30 days from today

*Note:* Adapted from: EngenderHealth. 2002.

## Session 28

# Helping Clients Develop Skills in Partner Communication and Negotiation

By the end of this session, you should be able to:

- Identify reasons that clients may have for not talking with their partners about SRH concerns
- Recognize deeper personal and social issues behind clients' difficulties in discussing SRH issues with partners
- Help clients discuss SRH issues more effectively with partners, even in relationships in which there is violence or a power imbalance between partners

### *Essential Ideas—Session 28*

- There are many reasons why clients may feel that they cannot discuss SRH concerns with their partners; identifying these is an important first step in helping clients to determine whether they can move past these blocks and find ways to start these important conversations.
- It is equally important to address the deeper fears or social issues behind clients' reasons for not talking with their partners. Identifying these root factors can help clients understand their fears and anxieties related to talking with their partners and develop strategies for overcoming them.
- Clients' reasons for not feeling they can discuss sexuality openly can be *real* or *perceived*. A provider needs to respect the client's reasons, even if the perception does not fit the provider's view of the actual situation.
- If a client does not feel that she is able to discuss condoms, do not force her. Try to encourage her to come back for further discussion. In the end, however, she knows her relationship best. Urging her to press this issue when there is a power imbalance, especially when violence or abuse have occurred, could end up placing the woman's health and life in danger.
- Even when there is a power imbalance or violence in a relationship, a woman has options for negotiating safer sex and contraception. This often requires some creativity and a willingness to adapt to the partner's needs. Many of these options can be considered "survival strategies," as they are options of last resort and serve to reduce harm. While you may find this frustrating or even challenging, it is important to work within the client's situation without being judgmental.

*(continued)*

*Essential Ideas—Session 28 (continued)*

- Do not criticize the partner or spouse. Also, do not simply suggest to a woman that she leave her partner. Abusive or controlling relationships are rarely resolved by suggesting that the woman leave, nor is that always her best or most realistic option.
- You should be aware of any services available in their community for women who are in abusive relationships or who live with gender-based violence, and you should put into place mechanisms for referral.

**Barriers to Talking with Partners about SRH Concerns**

<b>Clients' reasons</b>	<b>Deeper personal and social factors</b>
My partner will think I am cheating if I ask him to use condoms.	Fear of losing the relationship
We love each other, so why should we use condoms?	Denial
We do not talk about things like that.	Following social norms and values; fear of change
People like me do not get HIV or STIs.	Misinformation about how HIV and STIs are transmitted; denial; lack of risk-perception
My partner will think I have HIV or an STI if I ask to use condoms, and he will kick me out of the house and tell everyone about it.	Fear of retribution, loss of support, etc.
I do not want my partner to know that I have other sexual partners.	Fear of a negative reaction
I cannot tell him that I am unhappy with our sex life—he will find someone else.	Fear of abandonment
I cannot tell him that it hurts because it is a woman's obligation to have sex with her husband any way that he wants.	Following social norms and values
I cannot tell her that I have an STI because then she will know that I cheat on her.	Fear of a negative reaction
I cannot tell him that I want to use family planning because he thinks that it goes against our religion.	Following social norms and values
I cannot ask him about his smelly discharge because he will get embarrassed.	Fear of hurting feelings, embarrassing partner

*Note:* Adapted from: EngenderHealth, 2002.

## Discussion Summary

Women face challenges to discussing SRH concerns with their partners under the best of circumstances. How is this further complicated when there is a power imbalance, violence, or abuse in the relationship?

- Fewer options are available to a woman who is controlled or abused by her partner.
- She feels greater pressure to “fix” what is wrong with the relationship.
- The woman may be suffering from depression or a sense of hopelessness, and therefore may care less about taking care of herself through safer sex or family planning.

What suggestions can you, as providers, make to your clients for discussing sexuality issues and SRH concerns with their partners?

### *The client could:*

- Identify areas of family life or relationships that they *do* talk about. See if there is some way that these issues can be included in those discussions.
- Start the conversation by saying that this is something that she heard about in a talk at the clinic and by wondering if the partner knows anything about these issues.
- Compliment the partner or use another tactic to make him realize that he is still exercising his power by using condoms. (*Note:* This could be considered a “survival strategy.”)
- Say that she has some health issues that the provider wants to discuss with him (appreciating his role in the family) or some decisions that he needs to make with her.
- Identify family members (his family or hers) who may be supportive and ask them to help her communicate about these issues with her partner.

### *Notes to the provider:*

- Use role-playing with the client to practice these strategies. Sometimes it is helpful at first for the client to practice being the partner and for you to play the role of the client, to model how these issues can be discussed. Then switch roles, to give the client a chance to practice saying these things herself.
- Be nonjudgmental, of the partner as well as of the client. Criticizing the woman’s partner may threaten her sense of well-being and end your counseling relationship.
- Respect the client’s willingness and ability to negotiate with her partner. If she says that she cannot discuss this with her partner, explore other options. If there are truly no other options, schedule a follow-up visit and address the topic again.

## Part VII

# Final Steps in Implementing Integrated SRH Counseling

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The final sessions in this curriculum will help you actually practice or apply integrated SRH counseling by putting all of the components together. You will receive the opportunity to practice a complete counseling session in counseling role plays or in a clinical practicum, using skills and approaches covered in previous sessions and receiving feedback.

It is important for all to recognize that applying new counseling skills acquired in training requires more than training itself: Administrators and supervisors need to be supportive of new practices and approaches, to help you and your co-workers adjust to and sustain any changes that are required. Also, you will need follow-up from trainers and supervisors to help you overcome problems, continue to improve your skills, and maintain your commitment to providing integrated SRH counseling.

## Session 29

### Counseling Practice—Final

By the end of this session, you should be able to:

- Demonstrate integrated SRH counseling skills in role plays (or in a practicum), assessing the client's needs and risks, addressing content issues and counseling concerns, and applying the principles and approaches discussed in this training

#### *Essential Ideas—Session 29*

- This counseling practice is the culmination of all of the shorter practice sessions conducted throughout the training. As you try to “put it all together,” you may find it hard to remember specific steps or questions. This is normal when learning a new skill; it is even harder when trying to “relearn” an area in which you already have some skills and habits established.
- Remember that, whatever counseling framework you are using, the most important thing is to focus on the client's needs and how you can help him or her.
- As with any new skill, integrated SRH counseling gets easier with *practice*. After this workshop, you should continue to practice these counseling skills and discuss these subjects with co-workers, with friends, and with family members. You may laugh about how awkward you and others may feel, but *keep talking* about sexuality issues and about how important they are to your work, and one day doing so will no longer be awkward.
- Time is a major concern for most providers who are developing counseling skills, worrying that they will not have enough time to do “good” counseling. This, too, gets easier with practice. For this session, we ask you to think about ways that time could be saved in the role plays, and include your ideas in the feedback. (This will be discussed in more detail in Session 30.)

#### **Observation and Feedback Guide for Counseling Practice**

##### ***Rapport-building:***

How did the provider build rapport with the client?

##### ***Introducing the subject of sexuality:***

How did the “provider” let the “client” know that sensitive and personal questions might be asked? How did the “provider” try to make the “client” comfortable about this? Did the “provider” seem comfortable?

## Session 29

### ***Accurate assessment:***

How did the “provider” assess the “client’s” risk for HIV and STIs or for unintended pregnancy? How did the “provider” help the “client” explain any other concerns about his or her sexuality or reproductive health? What could the “provider” have done differently?

Did the “provider” miss any important cues or pieces of information from the “client”?

### ***Information giving:***

What specific information did the “provider” offer? What other information should have been given? What level of language was used? How did the “provider” talk about sexuality issues?

### ***Decision making:***

How did the “provider” assist the “client” to make his or her own decision?

### ***Implementing the decision:***

How did the “provider” help the “client” to develop a plan of action? Did the plan include reducing the risk of HIV and STI infection? If not, why not?

### ***Referral/revisit:***

Did the “provider” make referrals to services that could support the “client” in implementing his or her plans (for example, a referral to voluntary counseling and testing services)?

### ***Saving time:***

What could the “provider” have done to save time? What information could have been left out or covered by someone else?

## Session 30

# Meeting Providers' Needs and Overcoming Barriers to Offering Integrated SRH Counseling

By the end of this session, you should be able to:

- Describe three areas of the needs of health care staff and give examples of how these apply to integrated SRH counseling
- Identify barriers to providing integrated SRH counseling in the work setting and strategies for overcoming those barriers
- Name at least two strategies for saving time in counseling and explain how these can be applied in your own work setting

### *Essential Ideas—Session 30*

#### *Needs of Health Care Staff*

- The general needs of health care staff have been described in three categories:
  - Facilitative supervision and management
  - Information, training, and development
  - Supplies, equipment, and infrastructure

#### *Barriers*

- The most common barriers to providing integrated SRH counseling that are cited by health care staff are:
  - Lack of sufficient time to properly counsel individual clients
  - Lack of space to ensure privacy during counseling and confidentiality during staff discussions
  - Lack of support from co-workers and supervisors for changes (e.g., in space and time) that may be required for counseling to be provided effectively
  - Lack of awareness among other staff about the importance of counseling
  - Embarrassment about raising with clients issues of sexual relationships and behaviors
  - Reluctance to identify the SRH needs of clients that cannot be met on-site or for which a referral site is not known (or for which services do not exist)

#### *Strategies for Saving Time*

- *Accurate assessment:* The key to reducing counseling time is to accurately assess the client's needs, knowledge, and concerns and then to prioritize which need to be addressed now and which can be taken care of later or elsewhere.

*(continued)*

*Essential Ideas—Session 30 (continued)*

- *Tailoring information-giving to the client's needs:* It is critical not to waste time by providing information that the client does not need or already knows. A good rule of thumb is that the client should do most of the talking at the beginning of the session, until you are clear about what the issues are and what decisions the client needs to make.
- *Group education prior to counseling:* As we saw in the session on using simple language, a lot of time can be saved in counseling by having group education talks prior to counseling. Also, if an intake worker or receptionist can gather basic information about the client, then the provider needs only to review this information.
- *Use of other staff:* In some health settings, nonmedical staff can handle basic levels of counseling, with clinical staff addressing diagnosis and treatment. In short, a team approach to counseling can be used to cover different aspects of a client's needs.
- *Referral and revisit:* Another important strategy to make counseling more efficient is referring clients to other services for specialized counseling or SRH services not provided in this setting. Also, a client can be asked to come back for a revisit on issues that are less urgent. The provider then can focus for that day on the highest-priority issues. However, requiring the client to return for additional services may create an unnecessary burden. Since a client may *not* follow up on a referral or show up for a revisit, it is important to be clear about priority needs and concerns and make sure that these are addressed while the client is with the provider.

## **The Needs of Health Care Staff**

### *Facilitative supervision and management*

Health care staff function best in a supportive working environment in which they receive facilitative management and supervision that provides clear performance expectations, motivates staff, enables them to perform their tasks well, and helps them better meet the needs of their clients.

### *Information, training, and development*

For a facility to provide quality health care services, staff must possess and continuously acquire the knowledge, skills, and attitudes needed to provide the best services possible.

### *Supplies, equipment, and infrastructure*

For health workers to provide quality health care services, staff need reliable and sufficient supplies, equipment in working order, and adequate infrastructure.

*Note:* Adapted from: Huezo & Diaz, 1993.

## Session 31

# Individual Plans for Applying What Was Learned in This Training

By the end of this session, you should be able to:

- Identify three changes that you want to make in your work immediately to implement what you have learned in this training, and explain why
- Make action plans listing specific activities, barriers that might be encountered, and strategies for overcoming them

### *Essential Ideas—Session 31*

- Some of what was covered in this workshop may not have been new to you; some of it may have been completely new. Some of it may have made you feel good about your work, while some of it may have made you feel that you will never be able to do integrated SRH counseling (or perhaps that you do not even want to). As these ideas settle in, you may try out and reject some strategies and try out and keep others. Some ideas you may share with colleagues or friends or perhaps even sexual partners; others you might not have been able to accept and may bother you for weeks or months to come.
- All of this is okay. You are learning how to help people deal with life-and-death decisions affecting the most important, and yet the most private, part of their lives—their sexuality. This work is not easy. If it were, people would have figured out how to do this effectively a long time ago, and we would not have the rates of maternal mortality, teenage pregnancy, and HIV infection that are found today in the world.
- No kind of lasting change happens overnight, or even in the course of a six-day workshop. In the individual action plans, focus on *a few key ways* of applying what you have learned to your work setting, as soon as you get there. These concrete and probably small changes will give you a chance to practice what you have learned and to see how it works for you. Bigger changes will take more time, but they have to start with someone—and right now, that “someone” is you.
- During the Daily Wrap-Ups, you selected one activity that you could implement as soon as you return to work. This session is meant to remind you of those ideas and to give you a framework for implementing them.

*(continued)*

*Essential Ideas—Session 31 (continued)*

- Being clear about *why* you are carrying out these action plans will be very helpful if you encounter people who are curious or concerned about the changes they see or whose work is also affected by the changes you are making. Knowing why you want to make a change also gives you an idea of the desired “outcome”—e.g., to make clients more comfortable discussing these issues, to be able to cover more information with clients, to be able to address needs more accurately—and these point you toward concrete indicators for outcome evaluation.
- These action plans will be reexamined during follow-up visits after the training (see Session 32). We encourage you to share your plan with your supervisor when you return to your work site.

### Individual Plan for Applying What Was Learned

Specific action to be implemented immediately	Why do you want to make this change?	Challenges that might be encountered	Strategies for overcoming challenges

## Session 32

### Training Follow-Up

By the end of this session, you should be able to:

- Describe the follow-up plans of the host institution, of your own institutions, and of the trainers

#### *Essential Ideas—Session 32*

- One training does not make you an expert at integrated SRH counseling. Presumably, you already had some counseling skills before you started this workshop. Skills development comes with practice, and you will get better at this if you keep trying—and if you can receive feedback on how you are doing.
- A common failing of trainings like this is a lack of follow-up. Making changes on your own in your work setting can be difficult, and many people give up after a while, no matter how enthusiastic they were after the training. That is why the trainers and the host institution are committed to providing follow-on trainings and site visits, so you will have the needed technical and emotional support to change the way you work.

## Appendix A

# Family Planning Resource Materials

### Key Elements of GATHER

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# Key Elements of GATHER

## GREETING

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### **Make a Good Connection and Keep It**

In good counseling, providers and their clients often go through a series of connected and overlapping steps. These steps can be remembered by the letters in the word "GATHER." G stands for "Greet."

The provider's friendly, respectful greeting makes the client feel welcome. It makes a good connection between provider and client right from the start. A good connection builds trust, and clients rely on providers that they trust.

This good connection should be kept up. Throughout every visit, all clients deserve understanding, respect, and honesty from everyone they meet.

### ***How to Make Clients Feel Welcome***

- Make sure each client is greeted in a friendly, respectful way as soon as he or she comes in. The staff member who first greets clients should understand how important this job is.
- Try to have places for clients to sit while they wait.
- Make the waiting area cheerful and interesting. For example, you can find or make posters that give useful health information.
- Have brochures and pamphlets for clients to look at.
- Tell newcomers what to expect during their visit. This can be done in person, with pamphlets or signs, and perhaps even with a videotape. Invite clients to speak up and ask questions whenever they want.
- If a client will be examined or undergo a procedure, explain what will happen clearly and with reassurance.
- Point out the staff member who can help if a waiting client needs something or has a question.
- Be sure every client has privacy from being seen or heard by others during counseling and during any physical examination or procedure.
- Tell clients that information about them and what they say will not be repeated to others (confidentiality).
- Reassure and comfort clients if needed.

***Suggested exercise:*** Try to name at least two more ways to make clients feel welcome.

*Note:* This description of the elements of GATHER is adapted from: Rinehart, Rudy, & Drennan, 1998.

### *Key Words for Greeting*

Experienced health care providers know “key words.” These words and phrases help put clients at ease. They help clients recognize and express their needs. They help clients make good decisions for themselves. Key words save time, too: They go quickly to the heart of the matter.

Here are some providers’ key words for greeting clients. Of course, the right words may be different in different cultures.

*“Welcome to [name of health care facility or organization]. My name is [give name]. I am pleased that you have come.”*

*“How can we help you today?”* (Respond to the client’s answer by explaining what will happen next. For example, you might say, *“Have you visited us before? Please tell me your name so that we can give your records to the nurse.”* OR: *“Please have a seat here. We will be able to help you in about [state how many minutes].”*)

*Suggested exercise:* What key words do you know? You can share them with your colleagues. Also, you can ask your colleagues for key words that they use.

## ASKING

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### Why and How to Ask Questions

In GATHER, A stands for “Ask.” The provider **questions effectively** and **listens actively** to the client’s answers.

#### *Why Ask Questions?*

- To learn why the client has come
- To learn about the client’s circumstances, needs, and concerns
- To help the client express needs and wants
- To encourage the client to actively participate
- To help the client express feelings and attitudes, and so to learn how the client feels
- To help the client think clearly about choices
- To show the client that you care and are interested
- To learn the client’s knowledge and experience with family planning and other reproductive health
- To learn about behavior and situations that could affect the client’s reproductive health and health choices

You may need to ask all clients certain questions for your records. But the most important questions bring out what clients really want and how they feel. The best questions lead to answers that suggest more questions—like conversation between friends. No list of standard questions suits all clients.

#### *How Can You “Question Effectively”?*

- Use a tone of voice that shows interest, concern, and friendliness.
- Use words that clients understand.
- Ask only one question at a time. Wait with interest for the answer.
- Ask questions that encourage clients to express their needs. Examples are: “How would you feel if you became pregnant soon?” “How do you think your spouse feels about family planning?”
- Use words such as “then?” “and?” and “oh?” These words encourage clients to keep talking.
- When you must ask a delicate question, explain why—for example, asking about number of sexual partners to find out about sexually transmitted infection (STI) risk.
- Avoid starting questions with “why.” Sometimes “why” sounds as if you are finding fault.
- Ask the same question in other ways if the client has not understood.

### *Open-Ended Questions Work Better!*

The questions below are *open-ended questions*. They invite clients to give full, honest answers. They help clients think about their choices. The answer to an open-ended question often suggests the next question.

- “Could you please tell me your reasons for coming?”
- “What have you heard about this method?”
- “What questions do you have about family planning?”
- “How do you feel about that?”

The questions below are *closed-ended questions*. They require a specific answer, often just “yes” or “no.” They cut off discussion. Some of these are also *leading questions*. They push the client to answer in the way that the questioner wants.

- “Are you here for family planning?”
- “Have you heard of this method?”
- “Don’t you prefer this method?”
- “Don’t you think young women should avoid sex before they are married?”

## ASKING

**Responding to Clients' Feelings**

Family planning and other reproductive health concerns can be a very private matter for clients. When they talk about these subjects, they may feel embarrassed, confused, worried, or afraid. These feelings affect their decisions. Some feelings may make choices difficult. Some feelings may lead to choices that clients regret later.

How can you help clients deal with their feelings? First, ask about feelings and help clients talk about them. Give your full attention. Listen actively and question effectively. Watch clients' body movements and expressions. These can help you learn what clients feel.

Once you recognize clients' feelings, let them know in clear and simple words that you understand. This is called "reflecting feelings." At right are two examples.

You cannot change clients' feelings. Only they can do that. But when you reflect feelings, you are showing that you understand. You also are saying that it is all right to feel that way.

As clients talk about their feelings, they understand themselves better. Then they may find it easier to make wise and healthy choices.

**Reflecting Feelings****Example 1****Example 2**

### Can You Talk about Sex?

Even for experienced health care providers, discussing sex can be difficult. Using sexual terms or slang can be embarrassing. As a result, providers may not volunteer important information, answer clients' questions fully, or ask important questions about sexual behavior. Providers may even try to influence a client's choice of methods to avoid explaining use of condoms or vaginal methods (e.g., diaphragms or spermicide), for example.

But reproductive health and sex cannot be separated. To make healthy decisions, clients often need to discuss sexual behavior. Therefore, providers need to be comfortable with hearing and using sexual terms and also with using pictures or models of the body. Here are suggested exercises that can make discussing sex easier:

1. Make a list of terms and slang related to sex. Discuss how you feel about hearing and using these words. Compare the words for men with those for women. Do these words avoid negative meanings? Which words would you rather use? Do your clients understand these words?
2. When alone, look at your face in a mirror and say the words that make you uncomfortable. With practice, you will be more at ease and confident.
3. Practice using pictures or a model to show clearly how to put a condom on a penis.

Clients, too, often find it hard to talk about sex. Here are some tips for helping them:

- **Give clients sensitive information in other forms.** Then they can take it into account even if they do not want to discuss it openly. For example, posters, pamphlets, videos, radio, and TV can explain the risks of having more than one sex partner, the signs of STIs, or the need for condoms.
- **Starting discussion** about sex is often the most difficult step. How can you gently let clients know that you are willing to discuss sex but will not force them to do so? You might ask, "Did you see the wall chart about STIs in the waiting area? Did it raise any questions?" or "Some women say they worry that their husbands have other sex partners, but they do not know how to talk with their husbands about it. How do you think you would handle that situation?" From here, you can lead gradually to a more personal discussion if the client is willing.

## ASKING

**Guiding without Controlling**

Most clients want to make their own decisions with some guidance from the provider. Two principles are important to giving guidance:

- Each client's wishes—and not the provider's wishes—determine how much guidance to give. Different clients will want more or less guidance.
- Good guidance helps clients make their own decisions. Good guidance should not be controlling—that is, it should not make decisions for clients.

A provider can give guidance and protect the client's right to informed choice at the same time. (Hint: Asking questions instead of making statements can help to avoid controlling.)

Guiding (Try This!)	Controlling (Avoid This!)
<p>Telling the client clearly that the decision is his or hers, while offering help, too:  <i>"Together we can think through your decision, but the choice is yours."</i></p>	<p>Giving advice when not asked:  <i>"Well, if you want <b>my</b> opinion...."</i></p> <p>Substituting your decision for the client's:  <i>"If I were you, I would...."</i></p>
<p>Helping clients think about the effects of their choices—both good and bad:  <i>"The pill gives some women upset stomachs at first. What if this happened to you?"</i></p>	<p>Expressing personal judgments or criticism about the client's behavior:  <i>"Doing that is wrong. You should know better."</i></p>
<p>Helping clients think about their own lives:  <i>"With your schedule, what might remind you to take a pill every day?"</i></p>	<p>Demanding a quick decision with no time to consider:  <i>"That is the list of methods we have. Now which do you want?"</i></p>
<p>Taking cues from the client:  <i>"You said that you had several sex partners in the last year. This makes me think that you may need to protect yourself from STIs."</i></p>	<p>Stating the client's decision for her (or him):  <i>"I am sure you do not want this method."</i>            Instead, ask the client to state his or her own choice or wishes, and then reflect them back.</p>
<p>Mentioning common experiences of other people like the client. Be balanced:  <i>"With injectables, some women are happy when monthly bleeding stops, but other women avoid injectables for this reason."</i></p>	<p>Using the words <i>should</i>, <i>always</i>, <i>must</i>, and <i>never</i>.</p>
<p>Respecting each client's decisions about their own lives:  <i>"I understand that you must leave home and work in the city most of the time. Since that is so...."</i></p>	<p>Cutting off the client:  <i>"Time is short. Let us move on...."</i></p> <p>Assuming that all similar people have exactly the same needs:  <i>"You are not married, and all unmarried people need condoms for STI protection."</i></p>

**How to “Listen Actively”**

- Accept your clients as they are. Treat each as an individual.
- Listen to what your clients say and also how they say it. Notice tone of voice, choice of words, facial expressions, and gestures.
- Put yourself in your client’s place as you listen.
- Keep silent sometimes. Give your clients time to think, ask questions, and talk. Move at the client’s speed.
- Listen to your client carefully instead of thinking what you are going to say next.
- Every now and then repeat what you have heard. Then both you and your client know whether you have understood.
- Sit comfortably. Avoid distracting movements. Look directly at your clients when they speak, not at your papers or out of the window.

**Countering False Rumors**

Asking clients what they have heard about family planning methods or STIs often turns up rumors.

***What Are Rumors?***

Rumors are misinformation passed around the community, mostly by word of mouth. Rumors become widely known and are believed to be true, but often they are inaccurate or false. The original source is usually forgotten.

***Where Do Rumors about Reproductive Health Start?***

- Unintended mistakes when a person passes on what he or she has heard
- Traditional beliefs about the body and health
- Exaggerations to make a story more entertaining
- Lack of correct information due to unclear explanations from health care providers—or no explanation at all
- People trying to explain something that has no obvious explanation, such as an unexpected side effect
- Errors or exaggerations in news reports or mass-media entertainment
- Someone trying to hurt the reputation of family planning, other reproductive health care, or health care providers

***Tips for Dealing with False Rumors That Clients Have Heard***

- Clearly ask all new family planning clients what they have heard and what concerns they have about methods. These questions may bring out rumors.
- Explain politely why the rumor is not true. Also explain what is true in ways that the client understands.

**ASKING**

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- Find out what the client needs to know to have confidence in the family planning method, other reproductive health care, or the provider. Find out who the client will believe.
- Be aware of traditional beliefs about health. This awareness can help you understand rumors. It also can help you explain health matters in ways that clients can easily understand.
- Encourage clients to check with a health care provider if they are not sure about what they hear.

***Tips for Dealing with False Rumors in the Community***

- Find a credible, respected person who can tell people the truth and counter the rumor. Community leaders and satisfied users can be especially good.
- Try to figure out why the rumor started. Perhaps a real event needs to be explained.
- If rumors are circulating or perhaps even appear in the news, your director can contact reporters and editors and help them learn the true story. Your director could offer to be interviewed or to make a broadcast. Also, your director could offer to help reporters check out any future rumors.
- Encourage people to check first with health care providers before they repeat rumors.
- Prepare a simple handout or poster with correct information.

[*Note:* See Supplement A, page 185, for further tips on dealing with rumors and misconceptions about family planning methods.]

## TELLING CLIENTS INFORMATION

### Tailored and Personalized

In GATHER, T stands for “Tell.” The provider responds to the client’s situation, concerns, and needs. The provider tells the client information that helps the client reach a decision and make an informed choice.

To make wise choices, clients need useful, understandable information. This information should describe the client’s various options and explain possible results. To help with understanding, you can make information both **tailored** and **personalized**.

**Tailored information** is information that helps the client make a specific decision. In the “Ask” step of GATHER, you can learn what decisions the client is facing and what his or her preferences and concerns are. Then, in the “Tell” step, you can give specific information that helps the client make those decisions. You can skip information that makes no difference to the client to avoid overloading and confusing the client.

**Personalized information** is information put in terms of the client’s own situation. Personalizing information helps the client understand what the information means to him or her personally. (See example in box below.)

#### *Example*

#### *Information for a Man Deciding How to Protect Himself against HIV/AIDS*

**Good:** “Having certain other STIs can raise the chances of getting HIV/AIDS.”

**Better (tailored):** “For a person with more than one sex partner, the best protection against getting STIs during sex is using a condom every time.”

**Best (tailored and personalized):** “You mentioned that you have two girlfriends now. The best way to protect yourself *and* your girlfriends is using a condom every time you have sex with either of them.”

**Suggested exercise:** Imagine a specific client. Then tailor and personalize an important fact about reproductive health for that client.

### **Tailoring Information for Method Choice**

Family planning clients should have access to full information about all available methods. At the same time, describing every method in equal detail can be confusing to a client trying to choose a method. Here is an easy way to find out what the client needs to know:

- **Ask what method the client wants.** Most clients already have a method in mind. Unless there is a medical contraindication, it is best if *clients get the method they want*. They will

use it longer and more effectively. Make sure the client (1) understands the method, (2) has no medical reason to avoid it (see chart, “Helping Clients Choose a Family Planning Method,” page 165), and (3) knows other methods are available when he or she wants to switch.

- **What if the client cannot use that method?** *Ask what the client likes about that method, and then describe similar methods.* For example, a woman wants an IUD because it is long-acting, very effective, and reversible. But she cannot use an IUD for medical reasons. You can tell her about Norplant implants or injectables because these also are long-acting, very effective, and reversible.

### *Key Words for Telling*

#### ***“Do you have a method in mind?”***

Most new family planning clients already have a method in mind. The “Tell” step in good counseling about method choice **starts** with that method.

#### ***“And what is it about this method that you like?”***

This question helps check whether the client really understands the method. Any mistaken ideas can be gently corrected. Also, the provider can mention other available methods with the same advantages—in case the client does not know these other methods.

**Clients should receive the method that they want so long as they understand the method and there is no medical reason for them not to use it.**

**Find more ways to tell people about family planning methods.** Counseling is important, but providers also can tell people about methods in many other ways—for example, radio, television, newspapers, community and clinic presentations, pamphlets, and wall charts. Clients who know more about methods *before* counseling can make better decisions *during* counseling.

## TELLING CLIENTS INFORMATION

### Counseling Starts in the Community

Informing the community and counseling clients go hand-in-hand. The better that people are informed *before* counseling, the better that counseling can help clients make informed choices that meet their needs.

#### ***Why Give Community Talks and Hold Group Discussions?***

- To inform many people at once. This saves time.
- To establish a link between the community and the service providers.
- To tell the community about services.
- To start people thinking about their choices even before they meet with a health care provider.
- To save time during counseling for addressing each client's needs and helping the client learn instructions.
- To answer questions that people are too shy to ask.
- To start a continuing discussion in the community.
- To create a common understanding among people. This helps avoid rumors.
- To make people aware of risky reproductive health behavior and to encourage safer behavior.
- To help people share their experiences and support each other's healthy decisions.

#### ***When and Where?***

- When community groups meet.
- At workplaces and schools.
- At specially planned public gatherings.
- At other public events such as sports matches, fairs, and exhibitions.
- While clients wait in clinics.

#### ***Tips for Talks and Discussions***

- Find out in advance who the audience will be, what they know, and what they want to know.
- Prepare. Know your goals, main points, and a few discussion questions. Plan your time.
- To begin, introduce yourself and the topic.
- Help people feel at ease. In a small group, you could start a short game or ask people to introduce themselves.
- Start the discussion with clear, simple information.
- Use words that everyone understands.
- Use audiovisual materials, including sample contraceptives if appropriate.
- Help keep discussion going. Keep eye contact. Encourage people to comment and ask questions. Ask "what" and "how" questions in a respectful way.
- Invite people to talk about their own experiences.
- If the discussion strays from the topic, gently lead it back with an appropriate question.
- Summarize important points during the discussion and again at the end.
- Suggest one important action that every person there can take—for example, each person can tell one other person in the community something important that they have learned.

### Effectiveness of Family Planning Methods

This table shows how many women in every 100 women become pregnant during the first 12 months of using major family planning methods. Two rates are shown for each method. The rate shown under "As Commonly Used" is a typical, or average, rate. Some couples do better than this, and others do worse. The rate under "Used Correctly and Consistently" applies to couples who follow the use instructions exactly and make no mistakes. For both categories, the pregnancy rate associated with the use of *no* method is assumed to be 85 per 100.

Family planning method	Pregnancies per 100 women in first 12 months of use	
	As commonly used	Used correctly and consistently
Norplant implants	Less than 1	Less than 1
Vasectomy	Less than 1	Less than 1
Long-acting injectable contraceptives	Less than 1	Less than 1
Female sterilization	Less than 1	Less than 1
Intrauterine device (TCu-380A)	Less than 1	Less than 1
Progestin-only oral contraceptives during breastfeeding	1	Less than 1
LAM (for 6 months only)	2	Less than 1
Combined oral contraceptives	6-8	Less than 1
Male condoms	14	3
Diaphragm with spermicide	20	6
Fertility awareness-based methods	20	1-9
Female condoms	21	5
Spermicides	26	6

**Key:**

-  = very effective (0-1 failures per 100)
-  = effective (2-9 failures per 100)
-  = somewhat effective (10-30 failures per 100)

*For sources and further explanation, see: Hatcher et al., 1997, pp. 4-18 and 4-19.*

## TELLING CLIENTS INFORMATION

## Telling Clients about Family Planning Methods

Clients need to know about family planning methods before choosing one. Here is basic information about nine methods. You can mention all available methods, but tell clients most about the methods that interest them. (Remember that clients may already know something about some methods.) Then, with the checklists on pages 165 to 169, you can help your clients choose a method. (*Note:* Most methods do not protect against STIs, including HIV/AIDS. During sex, condoms are the best protection against STIs.)

HOW IT WORKS	ADVANTAGES	DISADVANTAGES
<b>Combined oral contraceptives (the pill)</b>		
<p>When a woman swallows a pill each day, her ovaries stop releasing eggs. She cannot become pregnant without an egg.</p> <p><b>Effectiveness:</b> Very effective if taken every day. Effective as usually used.* No STI protection. Also can be used for emergency contraception.</p>	<ul style="list-style-type: none"> <li>• No need to do anything at the time of sex.</li> <li>• Monthly periods are regular, light, short; cramps are milder and fewer.</li> <li>• Helps prevent iron deficiency anemia, ectopic pregnancy, ovarian and uterine cancer, and pelvic inflammatory disease (PID).</li> </ul>	<ul style="list-style-type: none"> <li>• Some women have upset stomach (especially in first three months) and or spotting or bleeding between menstrual periods, missed periods, mild headaches, breast tenderness, and/or slight weight gain.</li> <li>• Some women cannot remember to take a pill every day.</li> <li>• In rare cases, the pill causes stroke, heart attack, or blood clots deep in the leg, especially in women with high blood pressure and in women who smoke and also are 35 or older.</li> </ul>
<b>Male condom</b>		
<p>A very thin, flexible sheath that covers the man's erect penis during sex. It keeps sperm out of the woman's vagina. It also prevents many STIs from passing between sex partners.</p> <p><b>Effectiveness:</b> Effective if used correctly and every time. Only somewhat effective as usually used.* Best method for STI prevention.</p>	<ul style="list-style-type: none"> <li>• Only method proved to prevent STIs, including HIV/AIDS, and also pregnancy when used correctly with every act of sexual intercourse.</li> <li>• Helps prevent conditions caused by STIs, such as PID in women and infertility in both women and men.</li> <li>• No need to see a health care provider before using.</li> </ul>	<ul style="list-style-type: none"> <li>• Must take the time to put condom on erect penis before sex.</li> <li>• May decrease sensation.</li> <li>• May cause itching for a few people who are allergic to latex rubber.</li> </ul>

(continued)

\*For more information on method effectiveness, see the chart on page 156.

Telling Clients about Family Planning Methods (*continued*)

HOW IT WORKS	ADVANTAGES	DISADVANTAGES
<b>Female sterilization</b>		
<p>A specially-trained health care provider makes a small surgical opening in the woman's abdomen and closes off both tubes that carry eggs from the ovaries to the womb. Then these eggs cannot meet the man's sperm. The woman still has menstrual periods.</p> <p><b>Effectiveness:</b> Very effective and permanent.* No STI protection.</p>	<ul style="list-style-type: none"> <li>• A single procedure leads to effective, lifelong family planning.</li> <li>• Nothing to remember and no repeated clinic visits needed.</li> <li>• No known long-term side effects or health risks.</li> <li>• A woman can still have sex as usual.</li> </ul>	<ul style="list-style-type: none"> <li>• Usually painful for a few days after the procedure. Slight chance of infection or bleeding at incision, internal infection or bleeding, or injury to internal organs.</li> <li>• Usually not reversible.</li> </ul>
<b>Vasectomy</b>		
<p>A specially-trained health care provider makes a small surgical opening in the man's scrotum (the sac of skin that holds the testicles) and closes off both tubes that carry sperm from his testicles. The man still produces semen, but it has no sperm in it to make a woman pregnant.</p> <p><b>Effectiveness:</b> Very effective and permanent.* No STI protection.</p>	<ul style="list-style-type: none"> <li>• A single, quick procedure leads to effective, lifelong family planning.</li> <li>• A man can still ejaculate and have sex as usual.</li> <li>• No known long-term side effects or health risks.</li> </ul>	<ul style="list-style-type: none"> <li>• Not effective at once. Couple must use another method for at least three months.</li> <li>• Usually some discomfort for a few days after the procedure. Possibly also some pain, swelling, and bruising in the scrotum.</li> <li>• Usually not reversible.</li> </ul>
<b>Long-acting injectable contraceptives</b>		
<p>Injectables Depo-Provera (DMPA) and Noristerat (NET-EN) stop ovaries from releasing eggs. A woman cannot become pregnant without an egg. They also thicken cervical mucus so sperm cannot pass.</p> <p><b>Effectiveness:</b> Very effective when spaced three months apart (for DMPA) or two months apart (for NET-EN).* No STI protection.</p>	<ul style="list-style-type: none"> <li>• Private. No one else can tell that the woman is using contraception.</li> <li>• Long-term yet reversible. Each injection lasts at least three months (DMPA) or two months (NET-EN).</li> <li>• The woman has to remember only to return for her next injection.</li> </ul>	<ul style="list-style-type: none"> <li>• Changes in menstrual bleeding, such as light spotting at first and no periods after the first year of use. (Some women consider no periods an advantage.)</li> <li>• Some women gain some weight. (Some women consider this an advantage.)</li> <li>• If stopping to become pregnant, average four months longer wait before pregnancy than after other methods.</li> </ul>

*(continued)*

\*For more information on method effectiveness, see the chart on page 156.

## TELLING CLIENTS INFORMATION

Telling Clients about Family Planning Methods (*continued*)

HOW IT WORKS	ADVANTAGES	DISADVANTAGES
<b>Norplant implants</b>		
<p>Small, plastic capsules placed under the skin of a woman's arm slowly release a hormone. The hormone thickens cervical mucus so sperm cannot pass. Sometimes also stop ovaries from releasing eggs.</p> <p><b>Effectiveness:</b> Very effective.* No STI protection.</p>	<ul style="list-style-type: none"> <li>• Lasts at least seven years; fertility returns when capsules are taken out.</li> <li>• Nothing to remember. No need to do anything at the time of sex.</li> <li>• Helps prevent iron deficiency anemia and ectopic pregnancy.</li> </ul>	<ul style="list-style-type: none"> <li>• Changes in menstrual bleeding, especially spotting or bleeding between periods. Some women have no periods. (Some women consider no periods an advantage.)</li> <li>• Clinical procedure is needed to start or stop use.</li> </ul>
<b>Intrauterine device (IUD)</b>		
<p>A small, flexible plastic frame, often with copper wire or sleeves on it. A health care provider inserts the IUD into the woman's womb through her vagina. The IUD stops egg and sperm from meeting.</p> <p><b>Effectiveness:</b> Very effective.* No STI protection.</p>	<ul style="list-style-type: none"> <li>• Effective prevention of pregnancy for as long as 10 years. Fertility returns when IUD is taken out.</li> <li>• No need to do anything at the time of sex.</li> <li>• Can be inserted just after childbirth.</li> </ul>	<ul style="list-style-type: none"> <li>• Many women at first have longer, heavier menstrual periods, bleeding or spotting between periods, or more menstrual cramps or pain.</li> <li>• Clinical procedure is needed to start or stop use.</li> <li>• PID is more likely to follow STI infection if a woman is using an IUD.</li> </ul>
<b>Fertility awareness–based methods (including periodic abstinence)</b>		
<p>A woman learns to recognize the fertile time of her menstrual cycle. To prevent pregnancy, a couple avoids vaginal sex during the fertile time or else uses a barrier method or withdrawal.</p> <p><b>Effectiveness:</b> Effective if used correctly. Only somewhat effective as usually used.* No STI protection.</p>	<ul style="list-style-type: none"> <li>• No physical side effects.</li> <li>• Very little or no cost.</li> <li>• Most couples can use these methods if committed to them.</li> <li>• Acceptable to some religious groups that object to other methods.</li> </ul>	<ul style="list-style-type: none"> <li>• More effective methods take two or three months to learn. Calendar method takes six months of recording cycle length before it can be used.</li> <li>• Long abstinence may cause tension.</li> <li>• Some methods may be less reliable or difficult to use if woman is sick, has a vaginal infection, or is breastfeeding.</li> </ul>

*(continued)*

\*For more information on method effectiveness, see the chart on page 156.

### Telling Clients about Family Planning Methods (*continued*)

HOW IT WORKS	ADVANTAGES	DISADVANTAGES
<b>Vaginal methods (spermicides, diaphragm, cervical cap)</b>		
<p>A woman places a spermicide, or a diaphragm or cap with spermicide, in her vagina before sex. Spermicides kill sperm or stop their movement. Diaphragms and caps keep sperm out of the womb.</p> <p><b>Effectiveness:</b> Effective when used correctly and every time. Only somewhat effective as usually used.* Help prevent STIs.</p>	<ul style="list-style-type: none"> <li>• Woman-controlled method for use when needed.</li> <li>• May help prevent some STIs and conditions caused by STIs.</li> <li>• No need to see a health care provider before using spermicides.</li> </ul>	<ul style="list-style-type: none"> <li>• May cause irritation. Can make urinary tract infections more common.</li> <li>• Woman must put method in vagina before every act of sexual intercourse.</li> </ul>

\*For more information on method effectiveness, see the chart on page 156.

## HELPING

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### Key Help from a Few Questions

In GATHER, H stands for “Help.” The client and provider discuss the choices, their different implications for the client, and how the client would feel about these. In this way, the provider helps the client consider key issues to help him or her reach a decision. Often, the choice is what family planning method to use. Other choices could be how to protect oneself from STIs or, for a young person, whether to begin having sex.

### Choosing a Family Planning Method

*First, ask the client if she or he already has a method in mind* (see “Telling Clients Information,” page 153). Then, with a few more questions, you can learn important information that will help you advise many of your clients. You can choose the best words to ask for this information.

Most clients who answer “no” to all three questions below can consider any available family planning method. Ask further questions as needed to help each client choose.

If a client answers “yes” to any of these three questions, see the advice below:

#### 1. *Is the client breastfeeding a baby? If so, for how long?*

- *Breastfeeding less than six weeks:*
  - Avoid hormonal methods. Combined oral contraceptives and monthly injectables can reduce milk supply. Progestin-only oral contraceptives, long-acting injectables, and Norplant implants in theory might affect the new baby’s growth.
  - All other methods can be considered. Fertility signs, used for fertility awareness–based methods, may be hard to interpret.
  - Between seven and 42 days after childbirth, postpone female sterilization.
- *Breastfeeding six weeks to six months:*
  - Avoid combined oral contraceptives and monthly injectables.
  - All other methods can be considered, including progestin-only oral contraceptives. Fertility signs may be hard to interpret.
- *Breastfeeding more than six months:*
  - Can no longer use lactational amenorrhea method (LAM).
  - All other methods can be considered, but combined oral contraceptives and monthly injectables are not the best choices. Fertility signs may be hard to interpret.

#### 2. *Do the client and his or her partner want any (more) children?*

- If so:
  - Couple should not choose vasectomy or female sterilization. These methods are permanent.

#### 3. *Does the client or his or her sex partner have sex with anyone else?*

- If so, the client:
  - Should always use condoms to protect against STIs
  - Can also use another method at the same time for extra protection against pregnancy
  - Should avoid the IUD

*Note:* All three questions are important. For example, a woman who has been breastfeeding for less than six months *and* who also has more than one sex partner should avoid combined oral contraceptives *and* should always use condoms.

### **Other Good Questions**

You may need to ask more questions to find out: Will the method that interests the client really suit the client's needs and way of life? Will the client be able to use the method effectively? Does the client have any medical condition that makes another choice better? The chart entitled "Helping Clients Choose a Family Planning Method" (page 165) helps answer these questions.

#### ***Key Words for Helping***

*"What have you decided to do?"*

After the client has considered all of his or her options, it is very important to ask the client this question. This is why:

- The question makes clear that a decision is needed.
- The question makes clear that the decision belongs to the client.
- By answering out loud, clients make a commitment to carry out their own decisions—or else recognize that they are not ready to decide.
- The client's answer tells you what the client wants—no need to guess or assume.
- If the client's answer is not clear or is out of keeping with previous discussion, you can ask more questions to be sure, and you can discuss the choice further.
- If the client's answer either is medically contraindicated or is based on unrealistic expectations, you can guide him or her to understand why it is not an appropriate choice.

*"So, you have decided to..."*

Reflect back the client's decision. Then the client can agree or disagree.

## HELPING

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### Is She Pregnant? Ask Questions to Find Out

A woman should try not to start certain family planning methods while pregnant.

Asking questions usually is enough to find out if a woman might be pregnant. Pregnancy tests and physical examinations usually are not needed, and they discourage clients.

**If the woman answers “yes” to any of these six questions,** it is reasonably certain that she is **not** pregnant. (Once she answers “yes” to a question, you can skip the other questions.)

- 1. Did she **give birth in the last six months, and is breastfeeding often, and has not yet had a menstrual period?**
- 2. Has she **abstained from vaginal sex since her last menstrual period?**
- 3. Did her **menstrual period start in the last seven days?**
- 4. Has she been **using family planning effectively and was her last menstrual period less than five weeks ago?**
- 5. Did she **give birth in the last four weeks?**
- 6. Did she **have an abortion or miscarriage in the last seven days?**

**If the client answers “no” to all of these questions,** she might be pregnant; pregnancy cannot be ruled out. Has she noticed signs of pregnancy? If so, try to confirm by physical examination.

**If her answers cannot rule out pregnancy,** the client should either have a laboratory pregnancy test or wait until her next menstrual period before starting combined or progestin-only oral contraceptives, injectables, Norplant implants, an IUD, or female sterilization. She can use condoms or spermicide until then. If she wishes, she can be given oral contraceptives, too, with instructions to start them when her menstrual period begins.

### Tips on Counseling Young Adults

Often young adults face different reproductive health issues than older clients. Young adults often are less knowledgeable and may lack the maturity to make well-considered decisions and carry them out responsibly. Thus, counseling young adults requires being even more open, more tolerant, more flexible, more knowledgeable, and more understanding. Counseling young adults can be challenging, but it can be very rewarding to help young people make wise and healthy decisions.

- **Be open.** Let young people know that no question is wrong, and that even embarrassing topics can be discussed.
- **Be flexible.** Talk about whatever issues the young person wants to discuss.
- **Give simple, direct answers** in plain words. Learn to discuss puberty and sex comfortably.
- **Be trustworthy.** Honesty is crucial to young clients. You—and the information you give—need to be believable. If you do not know an answer, say so. Then find out.
- **Stress confidentiality.** Make clear that you will not tell anyone else about the client’s visit, the discussion, or the client’s decisions.

- **Be approachable.** Do not get upset or excited. Keep cool.
- **Show respect,** as you do for other clients. Do not talk down to young clients.
- **Be understanding.** Recall how you felt when you were young. Avoid judgments.
- **Be patient.** Young people may take time to get to the point or to reach a decision. Sometimes several meetings are needed.

***Young Adults Are Special Clients. Keep This in Mind:***

- Young adults often need skills as much as facts. They need to learn how to deal with other people—including older people. For good reproductive health, important skills are knowing how to say no, how to negotiate, and how to make decisions.
- Young people often want to know how social relationships and sexual relationships fit together. Often, this is more important to them than facts about reproductive health.
- Young people often focus on the present. They find it hard to make long-range plans or to prepare for the distant future.
- Young people often find it hard to understand the idea of risk or risky behavior.
- Sexually active young adults often face a greater STI risk than older clients.
- A young person's sexual behavior may be forced or pressured—possibly by an older person.
- A young person may have sex only once in a while.
- A young person may plan not to have sex again but still do so.
- Young adults of the same age may have very different levels of knowledge and different sexual attitudes, behavior, and experiences.

***Suggested discussion:*** How do these points affect how you counsel young adults?

## HELPING

## Helping Clients Choose a Family Planning Method

1. Help Clients Think About Their Needs	2. Consider These Medical Conditions
<p>These questions help clients think about their needs. Discuss only methods that interest the client. Can you think of more questions?</p>	<p>For the client's preferred method, ask about these conditions and explain that they rule out its use. If needed, help the client choose another method.</p>
<b>Combined oral contraceptives (the pill)</b>	
<ul style="list-style-type: none"> <li>• Do you want an effective method that you can stop at any time?</li> <li>• Do you especially want to postpone or to space births?</li> <li>• Do you want a method that needs no action during sex?</li> <li>• Do you have heavy, painful menstrual periods or anemia?</li> </ul> <p><b><i>If so, the pill may be a good choice for you.</i></b></p> <ul style="list-style-type: none"> <li>• Do you dislike taking pills or do you forget them?</li> <li>• Would it be hard for you to get more pills?</li> <li>• Would you stop the pill if it made your stomach upset at first?</li> </ul> <p><b><i>If so, the pill may be a poor choice for you.</i></b></p>	<p><b><i>Should not be used by women who:</i></b></p> <ul style="list-style-type: none"> <li>• Smoke cigarettes and <i>also</i> are over age 35</li> <li>• Have blood pressure (bp) over 160/100 mm Hg; report high bp but cannot be checked</li> <li>• Are breastfeeding a baby less than 6 months old</li> <li>• Have had stroke or problems with heart or blood vessels due to blockages</li> <li>• Have or had breast cancer</li> <li>• Have active liver disease</li> <li>• Get bad headaches with blurred vision</li> <li>• Might be pregnant</li> <li>• Have unusual vaginal bleeding that suggests disease (until diagnosed)</li> <li>• Have long-term, severe diabetes</li> </ul>
<b>Male condom</b>	
<ul style="list-style-type: none"> <li>• Do you or your sex partner(s) need protection from STIs?</li> <li>• Do you have more than one sex partner? Does your partner?</li> <li>• Are you a man who wants responsibility for family planning?</li> </ul> <p><b><i>If so, condoms may be a good choice for you.</i></b></p> <ul style="list-style-type: none"> <li>• Would you or your partner find it difficult to use a condom with every sex act?</li> </ul> <p><b><i>Even so, you should use condoms if you need STI protection or have more than one sex partner. Can use another method, too.</i></b></p>	<p><b><i>Generally should not be used by someone:</i></b></p> <ul style="list-style-type: none"> <li>• As the only method if pregnancy would seriously threaten the woman's health. For most couples, condom use is only somewhat effective. Can use condoms for STI protection <i>and</i> another method at the same time, for greater protection from pregnancy.</li> <li>• Who has severe allergic reaction to latex.</li> </ul>

(continued)

**Helping Clients Choose a Family Planning Method (continued)**

<p><b>1. Help Clients Think About Their Needs</b>                  These questions help clients think about their needs.                  Discuss only methods that interest the client.                  Can you think of more questions?</p>	<p><b>2. Consider These Medical Conditions</b>                  For the client's preferred method, ask about these conditions and explain that they rule out its use.                  If needed, help the client choose another method.</p>
<p><b>Female sterilization</b></p>	
<ul style="list-style-type: none"> <li>• Are you sure you will want no more children? Is your husband?</li> <li>• Do you want a very effective, permanent method with no upkeep?</li> </ul> <p><i>If so, female sterilization may be a good choice for you.</i></p> <ul style="list-style-type: none"> <li>• Are you single or have no children?</li> <li>• Are you having marriage problems?</li> <li>• Are you worried about surgery?</li> </ul> <p><i>If so, female sterilization may be a poor choice for you.</i></p>	<p><b>No medical conditions restrict female sterilization, but some conditions call for delay, special care, or a special facility. These include:</b></p> <ul style="list-style-type: none"> <li>• Gynecologic or obstetric conditions, such as pregnancy, infection, cancer</li> <li>• Certain heart or blood vessel problems, such as high blood pressure</li> <li>• Long-term diabetes</li> <li>• Severe iron deficiency anemia</li> <li>• Between seven days and six weeks after giving birth</li> </ul>
<p><b>Vasectomy</b></p>	
<ul style="list-style-type: none"> <li>• Are you sure you will want no more children? Is your wife?</li> <li>• Do you want to take responsibility for family planning?</li> <li>• Do you want an effective, permanent method with no upkeep?</li> </ul> <p><i>If so, vasectomy may be a good choice for you.</i></p> <ul style="list-style-type: none"> <li>• Are you single or do you have no children?</li> <li>• Are you having marriage problems?</li> </ul> <p><i>If so, vasectomy may be a poor choice for you.</i></p>	<p><b>No medical conditions restrict the use of vasectomy, but some conditions call for delay, special care, or a special facility. These include:</b></p> <ul style="list-style-type: none"> <li>• Infection (including STIs), swelling, or lumps in penis or scrotum</li> <li>• Undescended testicle</li> <li>• Diabetes</li> </ul>

(continued)

## HELPING

### Helping Clients Choose a Family Planning Method *(continued)*

<b>1. Help Clients Think About Their Needs</b> These questions help clients think about their needs. Discuss only methods that interest the client. Can you think of more questions?	<b>2. Consider These Medical Conditions</b> For the client's preferred method, ask about these conditions and explain that they rule out its use. If needed, help the client choose another method.
<b>Long-acting injectable contraceptives</b>	
<ul style="list-style-type: none"> <li>• Do you want to keep your family planning private?</li> <li>• Do you want a long-lasting, very effective, reversible method?</li> <li>• Do you prefer injections?</li> </ul> <p><b><i>If so, an injectable may be a good choice for you.</i></b></p> <ul style="list-style-type: none"> <li>• Would you mind if menstrual bleeding changes or stops?</li> <li>• Would you mind some gradual weight gain?</li> <li>• Would you want to become pregnant quickly after stopping?</li> </ul> <p><b><i>If so, an injectable may be a poor choice for you.</i></b></p>	<p><b><i>Should not be used by women who:</i></b></p> <ul style="list-style-type: none"> <li>• Are breastfeeding a baby less than 6 weeks old</li> <li>• Have heart or blood vessel problems due to blockages, or have had a stroke</li> <li>• Have or have had breast cancer</li> <li>• Have active liver disease</li> <li>• Might be pregnant</li> <li>• Have unusual vaginal bleeding that suggests disease (until diagnosed)</li> </ul>
<b>Norplant implants</b>	
<ul style="list-style-type: none"> <li>• Do you want a long-lasting, very effective, reversible method with no upkeep?</li> </ul> <p><b><i>If so, Norplant implants may be a good choice for you.</i></b></p> <ul style="list-style-type: none"> <li>• Would you mind changes in menstrual bleeding?</li> <li>• Are you worried about minor surgery?</li> </ul> <p><b><i>If so, Norplant implants may be a poor choice for you.</i></b></p>	<p><b><i>Should not be used by women who:</i></b></p> <ul style="list-style-type: none"> <li>• Are breastfeeding a baby less than 6 weeks old</li> <li>• Have active liver disease</li> <li>• Have or have had breast cancer</li> <li>• Might be pregnant</li> <li>• Have unusual vaginal bleeding that suggests disease (until diagnosed)</li> </ul>

*(continued)*

### Helping Clients Choose a Family Planning Method *(continued)*

<p><b>1. Help Clients Think About Their Needs</b></p> <p>These questions help clients think about their needs. Discuss only methods that interest the client. Can you think of more questions?</p>	<p><b>2. Consider These Medical Conditions</b></p> <p>For the client's preferred method, ask about these conditions and explain that they rule out its use. If needed, help the client choose another method.</p>
<p><b>Intrauterine device (IUD)</b></p>	
<ul style="list-style-type: none"> <li>• Do you want a long-lasting, very effective, reversible method with little upkeep?</li> <li>• Are you in a mutually faithful sexual relationship?</li> </ul> <p><b><i>If so, the IUD may be a good choice for you.</i></b></p> <ul style="list-style-type: none"> <li>• Do you have more than one sex partner? Does your partner?</li> <li>• Do you have painful or long menstrual periods?</li> <li>• Would you mind touching your genitals to check the IUD strings?</li> </ul> <p><b><i>If so, the IUD may be a poor choice for you.</i></b></p>	<p><b><i>Should not be used by women who:</i></b></p> <ul style="list-style-type: none"> <li>• Have or might get STIs, including HIV/AIDS; had an STI or PID in the last three months</li> <li>• Might be pregnant</li> <li>• Have usual vaginal bleeding that suggests disease (until diagnosed)</li> <li>• Gave birth more than 48 hours but less than four weeks ago</li> <li>• Have infection following childbirth or abortion</li> <li>• Have cancer of a female organ or pelvic tuberculosis</li> </ul>
<p><b>Fertility awareness–based methods (including periodic abstinence)</b></p>	
<ul style="list-style-type: none"> <li>• Can you and your partner agree to avoid vaginal sex during the fertile time, or else to use a barrier method or withdrawal?</li> <li>• Do your religious or moral beliefs forbid other methods?</li> <li>• Do you worry about side effects with other methods?</li> </ul> <p><b><i>If so, these methods may be a good choice for you.</i></b></p> <ul style="list-style-type: none"> <li>• Would charting cycles or noticing fertility signs be difficult?</li> <li>• Would abstinence be difficult for you or your partner?</li> <li>• Would you be very upset if you became pregnant?</li> </ul> <p><b><i>If so, these methods may be a poor choice for you.</i></b></p>	<p><b><i>Generally should not be used by women:</i></b></p> <ul style="list-style-type: none"> <li>• If pregnancy would seriously threatened their health, unless other methods are not acceptable. For most couples, these methods are only somewhat effective.</li> </ul> <p><b><i>No medical conditions restrict the use of these methods, but some conditions can make fertility signs harder to recognize:</i></b></p> <ul style="list-style-type: none"> <li>• Recent childbirth or abortion, breastfeeding, or other conditions affecting the ovaries, such as stroke, serious liver disease, thyroid conditions, cervical cancer</li> <li>• STIs or PID in the last three months; vaginal infection (These affect cervical mucus.)</li> <li>• Irregular menstrual periods (These may make the calendar method difficult or ineffective.)</li> </ul>

(continued)

**Helping Clients Choose a Family Planning Method (continued)**

<p><b>1. Help Clients Think About Their Needs</b>                  These questions help clients think about their needs.                  Discuss only methods that interest the client.                  Can you think of more questions?</p>	<p><b>2. Consider These Medical Conditions</b>                  For the client's preferred method, ask about these conditions and explain that they rule out its use.                  If needed, help the client choose another method.</p>
<p><b>Vaginal methods (spermicides, diaphragm, cervical cap)</b></p>	
<ul style="list-style-type: none"> <li>• Do you want a method a woman controls and can use when needed?</li> </ul> <p><i>If so, vaginal methods might be a good choice for you.</i></p> <ul style="list-style-type: none"> <li>• Do you want a very effective method?</li> <li>• Do you dislike touching your genitals?</li> <li>• Would you sometimes forget the method or choose to ignore it?</li> </ul> <p><i>If so, vaginal methods may be a poor choice for you.</i></p>	<p><b>Generally, should not be used by women:</b></p> <ul style="list-style-type: none"> <li>• If pregnancy would seriously threaten their health (For most couples, vaginal methods are only somewhat effective.)</li> </ul> <p><b>The diaphragm or cap should not be used by women who:</b></p> <ul style="list-style-type: none"> <li>• Gave birth up to six to 12 weeks ago (Proper fitting can be difficult.)</li> <li>• Are allergic to latex</li> <li>• Have an unusually shaped cervix or vagina that keeps a diaphragm or cap from fitting</li> <li>• Have had toxic shock syndrome</li> </ul>

[Note: See Supplement B, page 186, for ideas on talking with clients about side effects.]

## EXPLAINING

### Explaining So Clients Remember

In GATHER, E stands for “Explain.” The provider explains to the client how to carry out the client’s decision. Often the provider gives instructions. (See the chart “Explaining How to Use the Chosen Method” [page 174] for instructions about family planning methods.) When explaining, the provider tries to tailor and personalize instructions to suit the individual client’s way of life (see “Telling Clients Information,” page 153).

#### *Key Words for Explaining*

#### **“Do you think you can do this? What might stop you?”**

If the client sees problems, you and the client can discuss ways to overcome them.

### 12 Tips to Help Clients Remember

The way you give information—especially instructions—can help clients remember them:

1. **Keep it short.** Choose the few most important points that clients must remember.
2. **Keep it simple.** Use short sentences and common words that clients understand.
3. **Keep it separate.** Keep important instructions separate from information that does not need to be remembered.
4. **Point out what to remember.** For example, “These three points are important to remember:....” Then list the three points. Most important to remember is *what* to do and *when*.
5. **Put first things first.** Give the most important information first. It will be remembered best.
6. **Organize.** Put information in categories. For example: “There are four medical reasons to come back to the clinic.”
7. **Repeat.** The last thing you say can remind clients of the most important instruction.
8. **Show as well as speak.** Sample contraceptives, flipcharts, wall charts, and other pictures reinforce the spoken word. (See “Tips on Using Audiovisual Materials,” page 172.)
9. **Be specific.** For example, “check the IUD strings regularly” is not clear and not easy to follow. It is clearer to say, “Just after a menstrual period, wash your hands. Then put your finger high up in your vagina and feel the IUD strings. If the strings seem longer, shorter, or missing, or you feel something hard, come back to see us.”
10. **Make links.** Help clients find a routine event that reminds them to act—for example, “When you first eat something each day, think about taking your pill at that time.” or “Please come back for your next injection in the week after the summer festival.”
11. **Check understanding.** Ask clients to repeat important instructions. This helps them remember. Also, you can gently correct any errors.
12. **Send it home.** Give clients simple print materials to take home. Review this material with them first.

***Suggested Exercises***

- Without looking at the list on the preceding page, see how many of these 12 points you remember. What does this show?
- Think of an instruction that you often give to clients. Now try to say it again more simply.
- If you do not have pictures to show clients, make your own.

***Should Counselors Explain Side Effects? Yes!***

Does explaining side effects of a family planning method scare away clients? Does it make them worry needlessly? Or does explaining help clients handle side effects if they occur? *Research shows that clients use their method longer when counselors explain side effects in advance.* Possible side effects should be explained honestly and without alarm. Important messages are:

- Many people do not have any side effects.
- The most common side effects are **not** dangerous. Make this clear when explaining these side effects. Examples include nausea with combined oral contraceptives (the pill) and amenorrhea (no menstrual bleeding) with injectables.
- Many side effects go away without treatment. Many side effects can be treated.
- For most methods, there is a small risk of a serious complication. Explain the warning signs of such complications separately from side effects that are not dangerous.
- Clients are always welcome to come back with any concerns or questions or to change methods.

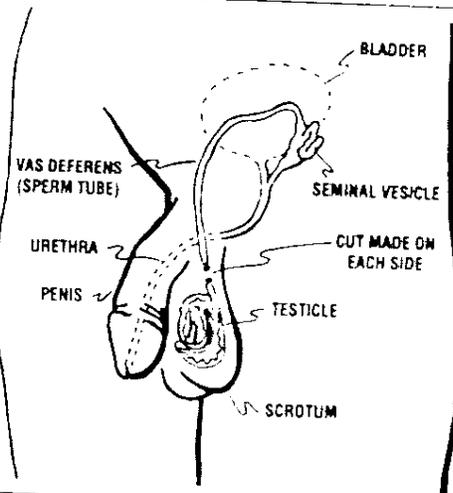
***Tips on Using Audiovisual Materials***

Audiovisual materials help clients learn and remember. These include sample contraceptives, wall charts, take-home pamphlets and wallet cards, flipcharts, audiotapes, videotapes, drawings, and diagrams such as those on page 173. Even simple, handmade audiovisual materials are better than none at all. Here are some tips on using audiovisual materials:

- Make sure clients can clearly see the visual materials.
- Explain pictures, and point to them as you talk.
- Look mostly at the client, not at the flipchart or poster.
- Change the wall charts and posters in the waiting room from time to time. Then clients can learn something new each time they come.
- Invite clients to touch and hold sample contraceptives.
- Use sample contraceptives when explaining how to use methods. Clients can practice putting a condom on a model penis, a stick, or a banana. Clients may want privacy for this.
- If possible, give clients pamphlets or instruction sheets to take home. These print materials can remind clients what to do. Be sure to go over the materials with the client. You can mention information, and the client will remember it when he or she looks at the print material later.
- Suggest that the client show take-home materials to other people.
- Order more take-home materials before they run out.
- Make your own materials if you cannot order them or if they run out.

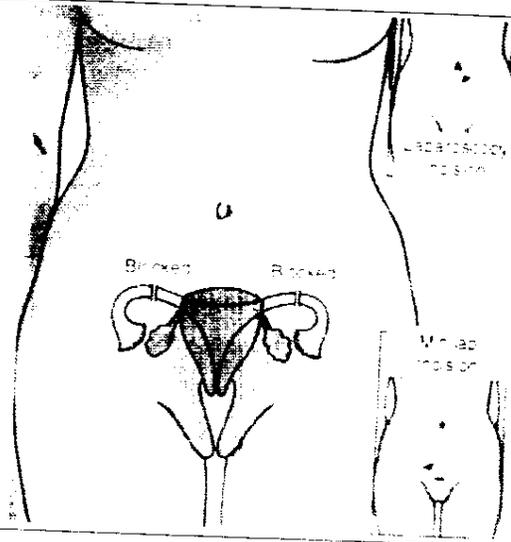
**Vasectomy**

You can use this picture to help tell clients how vasectomy is done. It shows how the man's tubes are cut to prevent sperm from leaving his body. For more description of the vasectomy procedure, see the chart "Explaining How to Use the Chosen Method," page 174.



**Female sterilization (tubal ligation)**

You can use these pictures to help tell clients how tubal ligation is done. The large picture shows where the tubes are blocked. The two small pictures show where the incision in the skin is made. The upper picture shows an incision for laparoscopy. The lower picture shows an incision for minilaparotomy. For more description of female sterilization procedures, see the chart "Explaining How to Use the Chosen Method," page 174.

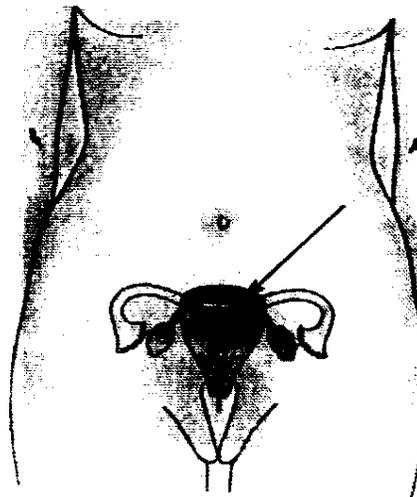


Note: Courtesy of Associação Brasileira de Entidades de Planejamento Familiar

**IUD (intrauterine device)**

You can use this picture to show clients where the IUD is placed in the womb.

Note: Courtesy of Associação Brasileira de Entidades de Planejamento Familiar



## Explaining How to Use the Chosen Method

Once your client has chosen a method, explain how to use it correctly. Explain only the method that the client has chosen. These explanations also can help remind returning clients about using their methods correctly.

### Combined oral contraceptives (the pill)

- You can start the pill any time it is reasonably sure that you are not pregnant—for example, during the first seven days after your menstrual period starts.
- Take one pill each day until the packet is empty.
- Then start the next packet. *For 28-pill packets:* Take the first pill from the new packet the next day. *For 21-pill packets:* Wait no more than seven days and then take the first pill.
- If you miss a pill, take it as soon as you can. Then take the next pill at the regular time, even if you take two pills at once or on the same day.
- Side effects sometimes occur, such as upset stomach, light bleeding between periods, very light menstrual periods, occasional missed periods, mild headaches, tender breasts, and moodiness. These side effects are not signs of serious sickness. They generally become less or stop in a few months. Keep taking one pill each day. Skipping pills makes some of these side effects worse.

**Warning Signs:** See a nurse or doctor if you have severe, constant pain in the belly, chest, or leg; if you start to get very bad headaches; if you see flashing lights or zigzag lines; or if your skin or eyes become unusually yellow.

### Male condom

- Put a condom on the erect penis before it touches the vagina.
- Put the condom on the tip of the penis with the rolled rim up (away from the body). The condom should unroll easily to the base of the penis.
- When withdrawing your penis after sex, hold the rim of the condom so that semen does not spill.
- Use each condom only once. Throw the used condom in a pit latrine or bury it.

**Warning:** Do not use lubricants with oil in them, such as Vaseline or butter. Oil weakens condoms.

[Note: See Supplement C, page 187, for further tips on proper condom use.]

(continued)

### Explaining How to Use the Chosen Method *(continued)*

#### Long-acting injectable contraceptives

- Try not to rub the injection site. This could shorten the protection.
- Try to come back for another injection in three months (for Depo-Provera) or two months (for NET-EN). But come back even if you must come early or you are late. If you are more than two weeks late, use condoms or a vaginal method until you can have another injection.
- Most women have changes in menstrual bleeding, and their periods may stop after a year. This is normal. It is *not* dangerous and does *not* mean you are pregnant.

**Warning Signs:** See a nurse or doctor if menstrual bleeding is twice as long or twice as heavy as usual for you; if you start to get very bad headaches; or if your skin or eyes become unusually yellow.

#### Norplant implants

- A specially-trained health care provider will place six small, plastic capsules under the skin of your upper arm. You will get medicine to prevent pain.
- Keep this area dry for four days. You can take off the gauze after two days and the bandage after five days.
- Most women have changes in menstrual bleeding, especially spotting or light bleeding between periods. This is normal. It is *not* dangerous and *not* a sign of danger.

**Warning Signs:** Come back if your arm is sore for more than a few days; if your arm becomes painful, hot, or red; if capsules come out; if very bad headaches start or become worse; if you might be pregnant (especially if you also have bad pain or tenderness in the belly or you feel faint); if you have very heavy vaginal bleeding; or if your skin or eyes become unusually yellow.

- You can have the capsules taken out any time you want. After seven years, you should have them taken out; you can get new capsules then if you want.

*(continued)*

## Explain How to Use the Chosen Method (continued)

### Intrauterine device (IUD)

- A specially-trained health care provider will insert your IUD. During the procedure, please tell the provider if you feel discomfort or pain. You may feel some cramps for a short time afterward.
- To make sure the IUD is still in place, check the IUD strings once a week for the first month and then from time to time after a menstrual period. Wash your hands, sit in a squatting position, and insert one or two fingers into your vagina until you feel the strings. Come back if you cannot feel the strings, if the strings feel longer or shorter, or if you feel something hard.
- Some women have longer, heavier menstrual bleeding, bleeding or spotting between periods, or more cramps. These are *not* danger signs.
- Plan to come back for a check-up in three to six weeks—for example, after a menstrual period.

**Warning Signs:** Come back if you miss a menstrual period or you think you might be pregnant; if you might get or have an STI, including HIV or AIDS; or if you have a very bad pain in the belly, especially pain with fever or with bleeding between menstrual periods (signs of PID).

- You can have the IUD taken out any time you want.
- You will get a written record of your type of IUD, when it was put in, and when you should have it removed. You can get a new IUD once this one has been removed.

### Fertility awareness-based methods (including periodic abstinence)

**Be aware of body changes. Remember these rules:**

- *Cervical secretions:* Avoid unprotected sex from the first day of any cervical secretions or feeling of vaginal wetness until the fourth day after the peak day of slippery secretions.
- *Basal body temperature (BBT):* Avoid unprotected sex from the first day of menstrual bleeding until the body temperature has risen and stayed up for three full days.
- *Cervical secretions plus BBT:* Avoid unprotected sex from the first day of cervical secretions until both the fourth day after the peak day of slippery secretions *and* the third full day after the rise in body temperature.
- *Calendar, or rhythm:* Avoid sex during the fertile time as figured from calculations based on six months of menstrual calendar records.

**Warning:** Providers not trained to teach these methods should refer clients.

### Vaginal methods (spermicides, diaphragm, cervical cap)

- Put spermicide, or diaphragm or cap with plenty of spermicide, into your vagina before sex.
- Spermicide alone can be put in up to an hour before sex. Put in foaming tablets, films, or suppositories at least 10 minutes before sex.
- Do not douche for at least six hours after sex. Leave a diaphragm or cap in place for at least six hours, but not longer than 24 hours for a diaphragm or 48 hours for a cap.

**Warning:** Providers should fit a diaphragm or cap, explain how to put it in and take it out, let the client try putting it in, and check that it is in place.

(continued)

Explaining How to Use the Chosen Method (continued)

Sterilization Procedures

Female sterilization

**Procedure:**  
Anesthetic (medicine to stop pain) is injected into the abdomen. You may also be given medicine to help you relax. (Tell the client whether she is going to be awake or asleep. Full sleep—general anesthesia—usually is not needed.) The procedure takes less than 20 minutes. Most women can leave the clinic in a few hours.

**There are two female sterilization procedures. Describe only what is available.**

**Minilaparotomy:**  
The provider makes a small incision in the belly just above the pubic hair. He or she moves the womb to bring each fallopian tube to the opening. This may cause discomfort. The provider ties and cuts both fallopian tubes or closes them with a clip or ring. Then the incision is sewn closed.

**Laparoscopy:**  
The doctor makes a small incision just under the navel and inserts a thin tube. The doctor puts an instrument inside this tube and uses it to close off or block both fallopian tubes. After taking out the instrument and tube, the doctor sews the incision shut or bandages it.

**After the procedure:**  
Rest for two or three days. Do not lift anything heavy for a week. Take paracetamol (Panadol or Tylenol) for pain, if needed.

**Warning Signs: Come back if you have fever; bleeding or pus in the wound; pain, heat, swelling, or redness of the wound that becomes worse or does not stop; abdominal pain or cramping that becomes worse or does not stop; diarrhea; fainting or extreme dizziness.**

Vasectomy

**Procedure:**  
Anesthetic is injected into the scrotum to stop pain. One or two small openings are made in the scrotum. The two tubes that carry sperm to the penis are cut. The ends are tied or closed off. The openings are sewn shut or bandaged. The procedure takes about 15 minutes.

**After the procedure:**

- If possible, put cold compresses on the scrotum for four hours to reduce swelling. Swelling and discomfort may last two or three days.
- Keep the incision clean and dry for two to three days. Take paracetamol (Panadol or Tylenol) for pain, if needed.
- Rest for two days and do not do heavy work or exercise for a few days.
- Use another effective method for at least three months.

**Warning Signs: Come back if you have high fever; bleeding or pus from the wound; or pain, heat, swelling, or redness at the wound that becomes worse or does not stop.**

## RETURNING

### **The Returning Client Deserves Attention, Too**

In GATHER, R stands for “Return.” All clients should be invited to return to their reproductive health care provider whenever they wish, for any reason.

At the same time, clients should not be made to come back when not necessary. For example, providers should give clients plenty of supplies and not schedule unneeded follow-ups.

### **Care for Continuing Clients**

All returning clients deserve attention, whatever their reason for returning. Returning clients deserve just as much attention as new clients.

Counseling a returning client should be flexible. It should be tailored to meet each client’s reasons for returning. The returning client should not be made to go through full method-choice counseling again.

Here are two general rules for counseling returning clients:

#### **1. Find out what the client wants.**

*To find out what the client wants, you can ask:*

- “How can we help you today? What would you like to discuss?”
- “What has been your experience with your family planning method (or other care)? Satisfied? Any problems? Do you want to switch methods?”
- “Any new health problems since your last visit?” (For the most part, a health condition that rules out a family planning method in the first place also means the client should switch methods if that condition develops during use.)
- “Any changes in sexual relationships or circumstances that would affect your risk for STIs?”

#### **2. Respond to what the client wants.**

- *If the client has problems, help resolve them.* This can include offering a new method or addressing a different SRH need.
- *If the client has questions, answer them.*
- *If the client needs more supplies, provide them generously.*
- *If appropriate, check whether the client is using the method correctly, and offer advice if not.*

See the chart “Return Visits Help Clients Continue” (page 181) for counseling returning users about their specific methods.

### *Key Words for Returning*

*“Please come back any time, for any reason.”*

*“I hope we see you again.”*

Making the client feel welcome *back* is as important as making the client feel welcome the first time.

### *Reasons to Return*

There are many good reasons for clients to return. For example, the client:

- Has questions or problems or wants advice
- Needs more supplies, another injection, or IUD or implants replaced
- Needs emergency contraception
- Needs a follow-up check after IUD insertion, female sterilization, or vasectomy
- Wants a different method—for any reason
- Wants an IUD or Norplant implants taken out
- Wants help with side effects
- Has noticed a specific medical reason to return (a “warning sign”)
- Brings a spouse, friend, or relative for services or information
- Wants to check on a rumor
- Needs condoms for STI protection
- Thinks he or she might have an STI
- Thinks she might be pregnant

## Return Visits Help Clients Continue

Clients are always welcome to return, for any reason—such as needing more supplies, seeking help with a question or problem, wanting an IUD or Norplant implants removed, or wanting to change methods for any reason. Returning clients deserve the same care and attention as new clients.

Return visits are good times to ask if clients are satisfied with their family planning choices and to answer questions or solve problems. Listen carefully, especially if clients have concerns about side effects. Do not dismiss a client's concerns or take them lightly. Here are suggestions to help clients who have problems with their methods. If a client is not satisfied after treatment and counseling, help the client choose another method.

### Combined oral contraceptives (the pill)

**Forgetting pills:** Suggest taking each pill at the same time every day—each morning upon waking, for example. Suggest that a family member help remind her.

*Note:* Urge the client to keep taking the pill even if she has any of the common side effects listed below. Skipping pills can make some side effects worse. In the first three months of use, mention that these side effects usually go away or become less after three months.

**Nausea** (common, not a sign of serious illness): Suggest taking the pill at night or with food.

**Slight headaches** (common, not a sign of serious illness): Suggest taking ibuprofen, aspirin, or paracetamol.

**Spotting or bleeding** (common, not harmful, but may bother the client): Missing pills is sometimes the cause of spotting or bleeding between periods. Encourage her to take a pill every day.

**Common side effects lasting longer than three months that bother the client:** Suggest a different low-dose combined oral contraceptive or a progestin-only pill. An alternative is to help the woman choose a different method.

**Amenorrhea** (no menstrual period) (common, usually not a sign of pregnancy): She probably is *not* pregnant if:

- She has had even a little bleeding
- She has taken a pill each day
- She missed the seven-day break between 21-pill packs

But if she has missed more than one active pill in a row, check for pregnancy. If she may be pregnant, tell her so, ask her to stop taking oral contraceptives, and give her condoms and or spermicide to use until it is clear whether or not she is pregnant.

(continued)

**Return Visits Help Clients Continue (continued)**

<b>Male condom</b>
<p><b>Itching:</b> Recommend a dry condom or one without spermicide; suggest water if lubricant is needed. If itching continues, examine the client for infection. If no infection and itching continues, help the client choose another method unless he or she is at risk for catching or transmitting an STI. If so, urge continuing condoms despite itching.</p> <p><b>Cannot use condoms consistently:</b> Discuss ways to make condoms part of each sex act. Remind the client that condoms are the only method proved to prevent both pregnancy and STIs, including HIV/AIDS. Give the client plenty of condoms so that supply is not a concern. If problems continue, discuss other methods. The client with high STI risk should think about using condoms and another family planning method together.</p>
<b>Female sterilization</b>
<p><i>Note:</i> Follow-up within seven days after the procedure is strongly recommended.</p> <p><b>Infection:</b> Clean the site with soap and water or antiseptic. Give oral antibiotics for seven days and check again.</p> <p><b>Abscess (pus present):</b> Clean site with antiseptic. Incise, drain pus, and treat the wound. Fever and chills may require hospitalization.</p>
<b>Vasectomy</b>
<p><i>Note:</i> Follow-up within seven days after the procedure is strongly recommended.</p> <p>A man can come back any time after three months if he wants his semen checked to make sure the vasectomy is working.</p> <p><b>Pain:</b> Check for blood clots in the scrotum. Small, uninfected clots require rest and pain-relief medication such as paracetamol. Large blood clots may need to be surgically drained. Infected clots require antibiotics and hospitalization.</p> <p><b>Infection:</b> Clean the site with soap and water or antiseptic. Give oral antibiotics for seven days and check again.</p> <p><b>Abscess (pus present):</b> Clean the site with antiseptic. Incise, drain pus, and treat the wound. Fever and chills may require hospitalization.</p> <p><b>Fear of impotence:</b> Assure the man that vasectomy does not physically change sexual desire, function, or pleasure.</p>

(continued)

## Return Visits Help Clients Continue *(continued)*

### Long-acting injectable contraceptives

**More than two weeks late for injection and sexually active:** If the woman might be pregnant, check for pregnancy. Unless she might be pregnant, give another injection if she wants it.

**Often late for injections:** Discuss ways for her to remember her next injection, such as linking the date to a holiday or change of season. Give the woman condoms to use if she cannot come for an injection on time.

**Spotting or bleeding:** Reassure her that this is normal and very common, especially in the first few months. It is not harmful. If this bleeding continues and still bothers the client, encourage her to return and discuss other family planning methods.

**Amenorrhea (no menstrual bleeding):** Reassure her that this is normal and common. It does *not* mean she is sterile, pregnant, or ill, or that menstrual blood is building up. It does *not* mean she will be unable to get pregnant when she stops using family planning. If amenorrhea continues to bother the client, discuss other methods.

### Norplant implants

*Note:* If a woman seems unhappy with her implants after discussion, always ask clearly whether or not she wants the implants removed, and do as she asks.

**Amenorrhea:** Reassure her that this is normal. It does *not* mean she is sterile, pregnant, or ill, or that menstrual blood is building up. It does *not* mean she will be unable to get pregnant when she stops using family planning. If amenorrhea continues to bother the client, remove the implants or refer for removal. Help her choose another method.

**Spotting and bleeding between periods:** Reassure her that this is normal and very common, especially in the first three to six months. It is not harmful.

**Infection at insertion site:** If there is no abscess (no pus present), do not remove capsules. Clean the site with soap and water or antiseptic. Give oral antibiotics for seven days and check again. If the site is abscessed, clean it with antiseptic, drain pus, remove capsules, and treat the wound. Insert a new set of capsules in the other arm, or help her choose another method if she prefers.

*(continued)*

### Return Visits Help Clients Continue (*continued*)

#### Intrauterine device (IUD)

*Note:* At the time of IUD insertion, plan a return visit for three to six weeks later. At that visit, ask if the woman has noticed:

- Signs of infection (increasing or severe pain in lower abdomen, especially if also fever and/or bleeding between menstrual periods)
- Signs that the IUD is out of place (strings seem shorter, longer, or missing, or she feels something hard in her vagina or at the cervix)

If either is suspected, arrange a pelvic examination.

#### **Irregular bleeding, or prolonged or heavy bleeding:**

*If signs of infection or other abnormality:* Arrange a pelvic exam and, if needed, appropriate care.

*If no signs of infection:* Ask whether she wants to keep her IUD or to have it removed, and do as she wishes.

*If no infection and less than three months since insertion:* Reassure the woman that changes in her menstrual bleeding are normal and will probably lessen over time. Encourage her to return if bleeding worsens.

*If no infection but very heavy bleeding more than three months since insertion:* Check for signs of severe anemia—pale under fingernails and inside eyelids. If she is anemic, recommend IUD removal and give iron tablets for three months. Help her choose another method.

**Lower abdominal pain that suggests PID:** Arrange for abdominal and pelvic exams. If symptoms suggest PID, treat as appropriate or refer for treatment. Generally, remove the IUD and help her choose another method. If another serious condition is found, such as ectopic pregnancy or pelvic mass, treat appropriately.

**Active STI infection:** A woman can keep her IUD if her clinician approves, if she has been or can be successfully treated, *and* if she is not likely to get an STI again. Otherwise, ask her to consider other methods, and recommend condoms.

**Client's or her partner's high-risk sexual behavior:** Ask the woman to consider other methods, and recommend condoms.

**Pregnancy less than 13 weeks:** Best to remove the IUD.

#### Fertility awareness–based methods (including periodic abstinence)

**Frustration and/or difficulty with abstaining from sex:** Discuss possible sexual interactions without vaginal intercourse that the couple can enjoy during the fertile time. If appropriate, suggest using condoms or spermicide instead of trying to avoid sex during the fertile time. If the problem cannot be resolved and leads to disputes, discuss whether another method would be better.

#### Vaginal methods (spermicides, diaphragm, cervical cap)

**Allergic reaction or sensitivity:** Check for signs of infection (abnormal vaginal discharge, redness and/or swelling of the vagina, itching of the vulva). Treat or refer. If no infection, suggest a different spermicide.

**Too messy:** Explain again how to insert spermicide, including the correct amount to use. If this continues to bother the client, help her choose another method.

## Supplement A

### Common Misconceptions about Family Planning Methods

<p><b>The pill (both combined and progestin-only pills)</b></p> <ul style="list-style-type: none"> <li>• The pill causes cancer.</li> <li>• A woman should take a break from the pill after some time.</li> <li>• The pill will cause deformed babies.</li> <li>• The pill can make a woman sterile.</li> <li>• A woman should not take the pill if she has not had a baby.</li> <li>• The pill can make a woman weak.</li> <li>• If a woman takes the pill for a long time, she will still be protected from pregnancy after she stops taking it.</li> </ul> <p><b>Injectables</b></p> <ul style="list-style-type: none"> <li>• Women without children cannot use DMPA.</li> <li>• DMPA causes cancer.</li> <li>• DMPA causes miscarriage.</li> <li>• DMPA makes a woman sterile.</li> </ul> <p><b>Norplant implants</b></p> <ul style="list-style-type: none"> <li>• Norplant implants cause cancer.</li> <li>• Norplant implants can break and move around within a woman's body.</li> </ul> <p><b>Female sterilization</b></p> <ul style="list-style-type: none"> <li>• Sterilization will change a woman's monthly periods.</li> <li>• Sterilization will make menstrual bleeding stop.</li> <li>• Sterilization will make a woman lose her sexual ability.</li> <li>• Sterilization will make a woman weak.</li> <li>• Sterilization will make a woman fat.</li> <li>• Sterilization involves inverting the uterus.</li> <li>• Sterilization can be undone at will.</li> </ul>	<p><b>Vasectomy</b></p> <ul style="list-style-type: none"> <li>• Vasectomy will make a man lose his sexual ability.</li> <li>• Vasectomy will make a man weak.</li> </ul> <p><b>Condoms</b></p> <ul style="list-style-type: none"> <li>• Condoms are mostly used by prostitutes.</li> <li>• Condoms will make a man weak and impotent.</li> <li>• Condoms often break during sex.</li> </ul> <p><b>IUD</b></p> <ul style="list-style-type: none"> <li>• An IUD can travel from the woman's uterus to other parts of her body, such as her heart or her brain.</li> <li>• An IUD will prevent a woman from having babies after it is removed.</li> <li>• A woman who has never had a baby cannot use the IUD.</li> <li>• A woman should have a "rest period" after using an IUD for several years.</li> <li>• An IUD will cause discomfort to the woman's partner during sex.</li> </ul> <p><b>Spermicides</b></p> <ul style="list-style-type: none"> <li>• Spermicides will cause birth defects.</li> <li>• Spermicides cause cancer.</li> </ul> <p><b>Diaphragm</b></p> <ul style="list-style-type: none"> <li>• The diaphragm is uncomfortable for the woman.</li> </ul> <p><b>LAM</b></p> <ul style="list-style-type: none"> <li>• LAM is not an effective family planning method.</li> <li>• Any type of breastfeeding can protect a woman from pregnancy.</li> </ul>
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Note: Information in this chart was adapted from Wells, 1995; Hatcher et al., 1997, and FHI, 2002.

## Supplement B

### Talking about Side Effects

Many service providers believe that explaining side effects of family planning methods scares away clients. Research shows the contrary: Clients use their method longer when counselors explain side effects in advance.

With new clients:

- Always explain side effects
- Tell clients that many people do not have side effects

With method users:

- Always acknowledge their complaint of side effects
- Take complaints seriously
- Understand what the exact complaint is

Tell and reassure:

- Why and how side effects occur
- Many side effects are harmless and not signs of danger
- Many side effects go away without treatment and many others can be treated
- In case of specific medical reasons (such as complications) to see a doctor or a nurse, explain these separately from side effects
- They are always welcome to come back with any concerns or questions
- They are always welcome to change methods

*Note:* Information in this chart was adapted from AVSC International, 1995; Hatcher et al., 1997; and Rinchart, Rudy, & Drennan, 1998.

## Supplement C

## Steps in Using a Male Condom

*Hint:* Make sure condoms are stored properly and obtained from a good source.

1. Check the manufacture or expiration date on the package.
2. Remove the condom from its package.

*Hint:* Do not use your teeth or a sharp object to open the condom package.

3. Unroll the condom slightly to make sure it unrolls properly.
4. Place the condom on the tip of the erect penis.

*Hint:* If a condom is initially placed on the penis backwards, do not turn it around; throw it away and start with a new one.

5. Squeeze the air out of the tip of the condom.
6. Unroll the condom down the penis.
7. Smooth out air bubbles.
8. With the condom on, insert the penis for intercourse.
9. After ejaculation, hold onto the condom at the base of the penis while withdrawing the penis.
10. Withdraw the penis while it is still erect.
11. Remove the condom from the penis.
12. Tie the condom to prevent spills or leaks.
13. Dispose of the condom safely.

Source: EngenderHealth, 2002.

## Appendix B

### Postabortion Care Resource Materials

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## Postabortion Counseling

Postabortion counseling:

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

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

According to the World Health Organization:

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

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

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

—WHO, 1995.

*Note:* The materials presented here are reprinted from EngenderHealth, 2003c.

## Counseling the Postabortion Client

### Preprocedure

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



### During the procedure

Maintain emotional support by providing:

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



### Postprocedure

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

## Counseling Guidelines for the Provider

### Before the PAC Procedure

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

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

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

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

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

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

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

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

*Note:* Adapted from: Winkler, Oliveras, & McIntosh, 1995.

## Appendix B

### After the PAC Procedure

Once the surgical procedure has been completed:

- Approach the client when she is already calm and recovering from the procedure. Be sensitive to her physical and emotional condition; forcing her to listen when she is not ready will just be a waste of your time and hers.
- Be flexible about where you conduct counseling. Sometimes clients may feel strong enough to get up and talk to the provider in a separate room; others may prefer to remain in bed and be counseled while still in the recovery room.
- Be aware that the important thing is to provide the client with useful information that is suitable to her needs.
- If others have accompanied the client to the service site, ask if she would like to include them in the discussion.
- Start the counseling by exploring the client's feelings, questions, and concerns after the postabortion procedure.
- Follow the postabortion counseling diagram (page 192) to check what information may be given to the client.
- Explore the client's postprocedure plans.
- Provide the client with the Postprocedure Information Sheet (page 195) and review it with her (and with others, as appropriate).
- Offer to help her with whatever she needs, as appropriate, before saying good-bye.

## Postprocedure Information Sheet

### How to Take Care of Yourself

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

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

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

### Avoid:

- Strenuous activity for two to three days
- Sexual relations until the bleeding has stopped

### What Is Normal:

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

### What Is Abnormal:

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

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

### Special Instructions:

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## Appendix B

### Simple Answers to Clients' Questions about Postabortion Family Planning

**Q: When can I resume sexual activity?**

A: After your bleeding has stopped.

**Q: How soon can I become pregnant?**

A: Almost immediately—even before your next period.

**Q: How can I avoid becoming pregnant again?**

A: Start using a family planning method now.

**Q: Which methods can I use right away?**

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

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

**Q: Which methods protect against STIs and HIV?**

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

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

*Note:* Adapted from: Winkler, Oliveras, & McIntosh, 1995.

## Statements on Contraception, Informed Choice, and Postabortion Care

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

—Winkler, Oliveras, & McIntosh, 1995.

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

—Winkler, Oliveras, & McIntosh, 1995.

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

—WHO, 1995.

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

—Wolf & Benson, 1994.

## Appendix B

### Individual Factors for Family Planning Counseling during Postabortion Care

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

Note: Adapted from: Winkler, Oliveras, & McIntosh, 1995.

## Guidelines for Contraceptive Use, by Clinical Condition

Clinical Condition	Recommendations	Precautions
No complications after treatment of incomplete abortion	<p>Consider all temporary methods.</p> <p><i>Norplant implants</i>: Can be used immediately.</p> <p><i>Injectables (DMPA, NET-EN)</i>: Can be used immediately.</p> <p><i>IUD</i>: Can be used immediately.</p> <p><i>Oral contraceptives (combined or progestin-only)</i>: Can be used immediately.</p> <p><i>Condoms (male/female)</i>: Can be used when sexual activity is resumed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film</i>: Can be used when sexual activity is resumed.</p> <p><i>Diaphragm or cervical cap</i>: Can be used when sexual activity is resumed.</p>	<p><i>Natural family planning</i>: Do not recommend until a regular menstrual pattern returns.</p> <p><i>Female sterilization</i>: The time of treatment for abortion complications usually is not the best time for clients to make decisions about methods that are permanent.</p> <p><i>Diaphragm or cervical cap</i>: Should be refit after a second-trimester abortion.</p>
<p>Confirmed or presumptive diagnosis of infection:</p> <ul style="list-style-type: none"> <li>• Signs and symptoms of sepsis/infection</li> <li>• Signs of unsafe or unclean induced abortion</li> <li>• Unable to rule out infection</li> </ul>	<p><i>Norplant implants</i>: Can be used immediately.</p> <p><i>Injectables (DMPA, NET-EN)</i>: Can be used immediately.</p> <p><i>Oral contraceptives (combined or progestin-only)</i>: Can be used immediately.</p> <p><i>Condoms (male/female)</i>: Can be used when sexual activity is resumed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film</i>: Can be used when sexual activity is resumed.</p> <p><i>Diaphragm or cervical cap</i>: Can be used when sexual activity is resumed.</p>	<p><i>Female sterilization</i>: Do not perform until infection is fully resolved (approximately three months) or until risk of infection is ruled out.</p> <p><i>IUD</i>: Do not insert until infection is fully resolved (approximately three months) or until risk of infection is ruled out.</p>
<p>Injury to genital tract:</p> <ul style="list-style-type: none"> <li>• Uterine perforation (with or without bowel injury)</li> <li>• Serious vaginal or cervical injury, including chemical burns</li> </ul>	<p><i>Norplant implants</i>: Can be used immediately.</p> <p><i>Injectables (DMPA, NET-EN)</i>: Can be used immediately.</p> <p><i>Oral contraceptives (combined or progestin-only)</i>: Can be used immediately.</p> <p><i>Condoms (male/female)</i>: Can be used when sexual activity is resumed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film</i>: Can be used when sexual activity is resumed (can be used following uncomplicated uterine perforation).</p> <p><i>Diaphragm or cervical cap</i>: Can be used when sexual activity is resumed (can be used following uncomplicated uterine perforation).</p>	<p><i>Female voluntary sterilization</i>: Do not perform until serious injury is healed.</p> <p><i>IUD</i>: Do not insert until serious injury is healed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film</i>: Do not begin use until vaginal or cervical injury is healed.</p> <p><i>Diaphragm or cervical cap</i>: Do not begin use until vaginal or cervical injury is healed.</p>

(continued)

Appendix B

Guidelines for Contraceptive Use, by Clinical Condition (*continued*)

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

## Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
<i>Nonfitted barrier methods:</i> latex and vinyl male/female condoms; and vaginal sponge and suppositories (foaming tablets, jelly, or film)	These methods may be used as soon as sexual intercourse is resumed.	<ul style="list-style-type: none"> <li>• Are inexpensive</li> <li>• Are good interim method if use of another method must be postponed</li> <li>• Require no medical supervision</li> <li>• In the case of condoms (latex and vinyl), provide protection against sexually transmitted infections (STIs), including HIV</li> <li>• Are easily discontinued</li> <li>• Are effective immediately</li> </ul>	<ul style="list-style-type: none"> <li>• Are less effective than IUD or hormonal methods</li> <li>• Require use with each episode of intercourse</li> <li>• Require continued motivation</li> <li>• Require resupply to be available</li> <li>• May interfere with intercourse</li> </ul>
<i>Fitted barriers used with spermicides:</i> diaphragm or cervical cap with foam or jelly	<p>The diaphragm can be fitted immediately after first-trimester abortion; after second-trimester abortion, fitting should be delayed until uterus returns to prepregnancy size (four to six weeks).</p> <p>Fitting the cervical cap should be delayed until bleeding has stopped and the uterus has returned to its prepregnancy size (four to six weeks).</p>	<ul style="list-style-type: none"> <li>• Are inexpensive</li> <li>• Require no medical supervision for use</li> <li>• Provide some protection against STIs, including HIV</li> <li>• Are easily discontinued</li> <li>• Are effective immediately</li> </ul>	<ul style="list-style-type: none"> <li>• Are less effective than IUD or hormonal methods</li> <li>• Require use with each episode of intercourse</li> <li>• Require continued motivation</li> <li>• Require resupply to be available</li> <li>• Are associated with urinary tract infections in some users</li> <li>• Require fitting by trained service provider</li> </ul>
<i>Oral contraceptives:</i> combined and progestin-only	Pill use may begin immediately, preferably on the day of treatment.	<ul style="list-style-type: none"> <li>• Are highly effective</li> <li>• Can be started immediately, even if infection is present</li> <li>• Can be provided by nonphysicians</li> <li>• Do not interfere with intercourse</li> </ul>	<ul style="list-style-type: none"> <li>• Require continued motivation and daily use</li> <li>• Require resupply to be available</li> <li>• May have reduced effectiveness if client has used certain medications (e.g., rifampin, dilantin, or griseofulvin) long-term</li> <li>• Necessitate condom use if client is at risk for STIs, including HIV</li> </ul>

(continued)

## Appendix B

### Guidelines for Selecting Contraception, by Method (*continued*)

Method	Timing postabortion	Advantages	Remarks
<i>Injectables:</i> DMPA and NET-EN	<p>Injection may be given immediately after first- or second-trimester abortion.</p> <p>Method may be appropriate for use if a woman wants to delay choice of long-term method.</p>	<ul style="list-style-type: none"> <li>• Are highly effective</li> <li>• Can be started immediately, even if infection is present</li> <li>• Can be provided by non-physicians</li> <li>• Do not interfere with intercourse</li> <li>• Are not user-dependent (except for injection every two or three months)</li> <li>• Do not require client to obtain supplies</li> </ul>	<ul style="list-style-type: none"> <li>• May cause irregular bleeding, especially amenorrhea (excessive bleeding may occur in rare instances)</li> <li>• May cause delayed return to fertility</li> <li>• Require injections every two or three months</li> <li>• Necessitate condom use if client is at risk for STIs, including HIV</li> </ul>
<i>Progestin-only implants:</i> Norplant implants	<p>Implants may be inserted immediately after abortion. If adequate counseling and informed decision making cannot be guaranteed, insertion must be delayed and an interim method provided.</p>	<ul style="list-style-type: none"> <li>• Are highly effective</li> <li>• Provide long-term contraceptive protection (effective for at least seven years)</li> <li>• Allow immediate return to fertility upon removal</li> <li>• Do not interfere with intercourse</li> <li>• Do not require client to obtain supplies</li> </ul>	<ul style="list-style-type: none"> <li>• May cause irregular bleeding (especially spotting) or amenorrhea</li> <li>• Require a trained provider to insert and remove</li> <li>• Are cost-effective only if used long-term</li> <li>• Necessitate condom use if client is at risk for STIs, including HIV</li> </ul>
<i>IUD</i>	<p>Insertion should be delayed until serious injury is healed, hemorrhage is controlled, or acute anemia improves.</p> <p>Insertion should be delayed until infection has been resolved (three months).</p> <p><i>First-trimester abortion:</i> IUD can be inserted if risk or presence of infection can be ruled out.</p> <p><i>Second-trimester abortion:</i> Insertion should be delayed for six weeks <i>unless</i> equipment and expertise for immediate postabortal insertion are available.</p>	<ul style="list-style-type: none"> <li>• Is highly effective</li> <li>• Provides long-term contraceptive protection</li> <li>• Allows immediate return to fertility upon removal</li> <li>• Does not interfere with intercourse</li> <li>• Does not require client to obtain supplies</li> <li>• Requires only monthly checking for strings (by client)</li> <li>• Requires only one follow-up visit, unless there are problems</li> </ul>	<ul style="list-style-type: none"> <li>• May increase menstrual bleeding and cramping during the first few months</li> <li>• Can result in uterine perforation during insertion</li> <li>• May increase risk of PID and subsequent infertility for women who have chlamydia or gonorrhea infection at the time of insertion</li> <li>• Necessitates condom use if client is at risk for STIs, including HIV</li> <li>• Requires a trained provider to insert and remove</li> </ul>

(*continued*)

Guidelines for Selecting Contraception, by Method (*continued*)

Method	Timing postabortion	Advantages	Remarks
<i>Female sterilization</i>	<p>Sterilization after a first-trimester abortion is similar to an interval procedure; sterilization after a second-trimester abortion is more similar to a postpartum procedure.</p> <p>Technically, sterilization procedures usually can be performed immediately after treatment of postabortion complications, unless infection or severe blood loss are present.</p> <p>Sterilization should not be performed until an infection is fully resolved (three months) or an injury healed.</p>	<ul style="list-style-type: none"> <li>• Is a permanent method</li> <li>• Is the most effective female method</li> <li>• Requires no further action once completed</li> <li>• Does not interfere with intercourse</li> <li>• Produces no change in sexual functioning</li> <li>• Causes no long-term side effects</li> <li>• Is immediately effective</li> </ul>	<ul style="list-style-type: none"> <li>• Requires adequate counseling and fully informed consent before being performed, which often is not possible at the time of emergency care</li> <li>• Has slight possibility of surgical complications</li> <li>• Requires trained staff and appropriate equipment</li> <li>• Necessitates condom use if client is at risk for STIs, including HIV</li> </ul>
<i>Natural family planning</i>	<p>Natural family planning is not recommended for immediate postabortion use. The first ovulation after an abortion will be difficult to predict, and the method is unreliable until after a regular menstrual pattern has returned.</p>	<ul style="list-style-type: none"> <li>• Is associated with no cost</li> <li>• Produces no change in sexual function</li> <li>• Has no long-term side effects</li> </ul>	<ul style="list-style-type: none"> <li>• Is difficult to use immediately after abortion</li> <li>• Necessitates use of alternative methods until normal cycles have resumed</li> <li>• Requires extensive instruction and counseling</li> <li>• Necessitates condom use if client is at risk for STIs, including HIV</li> <li>• Requires the woman and her partner to have continued motivation and a thorough understanding of how to use the method</li> </ul>

*(continued)*

## Appendix B

### Guidelines for Selecting Contraception, by Method (*continued*)

Method	Timing postabortion	Advantages	Remarks
<i>Vasectomy</i>	Vasectomy may be performed at any time.	<ul style="list-style-type: none"> <li>• Is a permanent method</li> <li>• Is the most effective male method</li> <li>• Requires no further action once completed</li> <li>• Does not interfere with intercourse</li> <li>• Produces no change in sexual functioning</li> <li>• Causes no long-term side effects</li> <li>• Is effective after 12 weeks following the procedure</li> </ul>	<ul style="list-style-type: none"> <li>• Requires adequate counseling and fully informed consent before being performed</li> <li>• Has slight possibility of surgical complications</li> <li>• Requires trained staff and appropriate equipment</li> <li>• Necessitates condom use if client is at risk for STIs, including HIV</li> <li>• Is not effective until after 12 weeks following the procedure</li> </ul>

Note: Adapted from: Winkler, Oliveras, & McIntosh, 1995.

## Appendix C

### Maternal Health Care Resource Materials

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## Counseling during Maternal Health Care

### Antenatal Counseling Approaches for the Customer, Family, and Community

Some information and counseling is targeted to the pregnant woman individually for her personal knowledge and behavioral change (“customer approach”). Other information needs to be delivered to important decision-making family members, like the husband or mother-in-law, as well as to the pregnant woman, for effective implementation (“family approach”). In addition, such messages are to be delivered to all strata of the community to raise awareness and cooperation (“community approach”).

### Customer Approach: Information for the Pregnant Woman

#### *Diet during Pregnancy*

- From the daily normal diet list, eat an extra handful of food at every meal or eat one additional meal every day. Additional food should include fruits and vegetables and foods rich in iron, such as beans, fish, meat, liver, kidney, eggs, and dark green, leafy vegetables. Drink plenty of clean (boiled) water.

#### *Rest and Activities*

- Rest after lunch and sleep at least six to eight hours at night.
- Avoid long and tiresome journeys and avoid work that requires prolonged periods of standing or sitting (i.e., more than four to five hours).
- Make regular antenatal care visits to the health clinic.
- Besides routine checkups, come to the health clinic at any time during the pregnancy or post-delivery period if you feel unwell.

#### *Personal Hygiene*

- Keep yourself adequately clean. Maintain your personal hygiene, including a daily shower, brushing your teeth, and breast care (i.e., in case of cracked or inverted nipples).
- Avoid tight-fitting clothes during this time.

#### *Immunization*

- Take tetanus-typhoid immunization at an appropriate time.

#### *Danger Signs during Pregnancy*

Pregnancy can cause some serious complications. On the other hand, a woman also may already have had a disease that is aggravated by the pregnancy. It is essential that you and your family know the signs of serious complications and what to do if they arise.

*Note:* The material presented here is adapted from: Bangladesh Ministry of Health and Family Welfare, NIPHP, 1999.

***Danger Signs during Pregnancy***

If the following signs are seen in a pregnant woman, she should be immediately taken to a health care center or hospital:

- Pale eyelids, tongue, gums, or palms, or a constant feeling of tiredness and shortness of breath (signs of severe anemia)
- Any vaginal bleeding before delivery, with or without pain
- High blood pressure equal to or more than 140/90 mm Hg
- Severe headache, blurred vision, or spots before the eyes
- Swollen hands, ankles, and especially face
- Convulsion or fits
- Jaundice (yellow coloration of the eyes) and dark urine
- Excessive vomiting
- High fever (persistent fever more than 40 degrees C)
- Insufficient weight gain (less than 2 kg every month after the first trimester)
- Leakage of fluid through the vagina
- Rupture of the membrane three weeks or more before the due date (i.e., before the 37th week of pregnancy)

**Family Approach: Information to Be Shared with Key Decision Makers in the Family**

***Danger Signs during Pregnancy***

Close relatives should be aware of danger signs during pregnancy, so that when these signs appear, the family member can immediately take the pregnant woman to a hospital or clinic.

***Preparation for Delivery***

Some preparation for delivery is essential. The following things should be discussed and arranged as the delivery date gets closer:

- Choose the site of delivery—home or institution
- Choose a delivery care provider—a traditional birth attendant, a nurse, or a doctor
- Make contact with centers with facilities offering comprehensive emergency obstetric care, and identify potential blood donors, if necessary
- Arrange transport to the health clinic, hospital, or emergency obstetric care site (even if using a traditional birth attendant)
- Arrange sufficient money
- Arrange for care of other children (if any) while the mother is away (if needed)

***Regular Antenatal Care Checkups***

The pregnant woman should be sure to receive checkups at regular intervals, as advised by the health clinic staff.

**Sexual Intercourse**

There are no restrictions to sexual intercourse except when there is a threat of miscarriage or a previous history of abortion during the first trimester.

**Activities to Avoid**

- Doing heavy work and lifting heavy items (e.g., carrying or lifting filled buckets or pitchers)
- Smoking, drinking alcohol, and taking medicines without appropriate medical consultation
- Visiting people who have communicable diseases such as chicken pox and measles

**Safe Delivery**

Safe delivery should be ensured by the presence of a traditional birth attendant or a service provider during delivery. Hospitals or institutions with delivery facilities are also recommended.

**Planning for after the Birth**

- Exclusive breastfeeding has important benefits for both the mother and the child up to six months after delivery, including feeding of the colostrum immediately after birth.
- Plans should be made for a family planning strategy after childbirth.
- The new mother should go to the clinic for postpartum care services.
- The baby should be given immunization regularly as a preventive measure against diseases.
- The baby should be taken to the nearest health facility for any kind of sickness.

**Community Approach: Messages to Be Delivered to the Community****Emergency Obstetric Care**

Advocate for taking women to emergency obstetric care facilities in emergency situations and for making more such facilities available, where needed.

**All Other Messages from the “Family Approach”**

Use community outreach to get all of the important messages included in the family approach (above) to family members in general and to community leaders, to build more awareness and community-based support for antenatal and postpartum care for women.

## Appendix C

### Phases of Counseling for Pregnant Women and Families

The content of information and counseling should vary during the antenatal period, in order to help the woman and her family to focus on key issues and to remember vital information. By dividing the messages into three “phases” (for each trimester), it is hoped that the message-giving will be easier for providers, and the pregnant woman and her family will better understand, memorize, and follow the messages.

#### *First-trimester Messages*

- Emphasize diet, rest, and personal hygiene
- Explain the danger signs of pregnancy
- Discuss the plan for delivery (birth plan)

#### *Second-trimester Messages*

- Repeat the danger signs of pregnancy, with emphasis on:
  - Whether weight is gained at a certain rate
  - Leakage of fluid through vagina
- Discuss the birth plan again
- Ask about tetanus-typhoid vaccination
- Explain the importance of feeding colostrum and of breastfeeding exclusively, and discuss correct method of breastfeeding
- Discuss care of the newborn baby
- Discuss the importance of family planning after delivery

#### *Third-trimester Messages*

- Finalize the birth plan
- Discuss the importance of postpartum visits and what to do if postpartum danger signs appear (see next section)
- Discuss danger signs during pregnancy, with emphasis on labor and delivery
- Repeat discussions about breastfeeding and the importance of feeding the colostrum to the newborn
- Discuss again the care of the newborn and family planning after delivery

### Postpartum Counseling Approaches for the Customer, Family, and Community

#### Customer Approach: Information for the Postpartum Woman

##### *Diet and Supplementary Food*

- Consume plenty of water and green, leafy vegetables, vegetables with a high water content, fresh fruits, eggs, fish, meat, and milk or milk products (Sour fruits should also be eaten.)
- Eat one extra handful of rice and one extra handful of beans (pulses) every day, one teaspoon of oil, and any seasonal fruit

- Take iron, folic acid, and calcium, as prescribed
- Take one vitamin A capsule (200,000 IU) within two weeks of delivery
- Use iodized salt in cooking; avoid taking excess salt
- Avoid drugs (without prior consultation with a doctor), cigarettes, chewing tobacco, and alcohol

### ***Rest, Exercise, and Other Activities***

- Get adequate rest
- For two months after delivery, avoid performing heavy physical activity and lifting heavy objects (such as lifting heavy baskets, buckets, or pitchers, or husking rice, among others)
- Gently exercise the perineum and lower abdominal muscles
- Allow the baby to breastfeed on demand, to prevent breast engorgement

### ***Personal Hygiene***

- Take a bath every day
- Clean your breasts and genitalia
- Use sanitary pads or clean cloths

### ***Newborn Care***

- Breastfeed *only* for up to six months (or following local health care guidelines)
- Immunize the newborn as per the immunization schedule provided by the health center
- Seek care for the baby immediately if he or she shows signs of diarrhea or acute respiratory infection

### ***Postpartum Danger Signs***

See box on page 212.

## **Family Approach: Information to Be Shared with Key Decision Makers in the Family**

### ***Newborn Care***

- Encourage the mother to breastfeed *only* for up to six months (or following local health care guidelines)
- Immunize the newborn as per the immunization schedule provided by the health center
- Seek care for the baby immediately if he or she shows signs of diarrhea or acute respiratory infection

### ***For the Mother's Health***

- Encourage the mother to take extra food
- Ensure vitamin A supplementation for the mother
- Be supportive of the couple's adopting a contraceptive method
- Help the mother to attend to the general needs of the baby
- Seek immediate medical care for the mother if she has any postpartum danger sign

## Appendix C

### *Postpartum Danger Signs*

If the following signs are seen in a woman after delivery, she should be taken immediately to a health care center or hospital:

- Fever (>38 degrees C)
- Bleeding that increases rather than decreases or large blood clots or pieces of placental tissue being passed
- Foul-smelling vaginal discharge
- Severe pain in the abdomen or pain that keeps increasing
- Signs of severe anemia (Hb <7 g per 100, breathlessness, palpitation, tiredness)
- Fainting, fits, or convulsions
- Severe pain in the chest or shortness of breath
- Pain, swelling, or redness in the breast
- Pain, swelling, redness, or discharge at the site of an incision (if the woman had a cesarean section or an episiotomy)
- Vomiting and diarrhea
- Urine or feces leaking out of the vagina
- Irritation or pain during urination

## Appendix D

### HIV and STI Resource Materials

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## What Are STIs and RTIs?

**Sexually transmitted infections (STIs)**—also known as sexually transmitted diseases (STDs)—are infections passed from person to person primarily by sexual contact.

Some STIs can be passed to a baby during pregnancy, delivery, or breastfeeding, causing serious complications. Some STIs, including **human immunodeficiency virus (HIV)**, the virus that causes **acquired immunodeficiency syndrome (AIDS)**, can also be passed through unclean surgical instruments, injection needles, and skin-cutting tools, as well as through transfusions of infected blood.

STIs are part of a broader group of infections known as **reproductive tract infections (RTIs)**. RTIs include infections of the reproductive system that:

- Are not caused by sexual contact, including infections caused by an imbalance of normal reproductive tract microorganisms (such as yeast infections)
- Are acquired during medical procedures (often when there is a failure in aseptic technique)

STIs can be divided into two broad categories: curable and incurable.

- **Curable STIs** can be treated with medications, such as antibiotics or antimicrobials. These STIs include syphilis, gonorrhea, chlamydia, trichomonas, lymphogranuloma venereum (LGV), chancroid, granuloma inguinale, pubic lice, and scabies. If not diagnosed and treated in time, some of these curable STIs can have serious—even fatal—consequences.
- **Incurable STIs**, such as HIV and AIDS, hepatitis B, genital herpes, and human papillomavirus (HPV), are caused by viruses. While these diseases cannot be cured, in some settings they can be managed by preventing, relieving, or reducing their symptoms. (HPV infection can often be treated with no recurrence.)

Infection with an STI might lead to symptoms in the reproductive organs themselves, in the skin around the genitals or anus, or in the throat or mouth. Some STIs may lead to systemic symptoms that cause problems in other parts of the body or throughout the body, while others may cause no symptoms at all. Common STI symptoms include:

- Abnormal discharge from the vagina or penis
- Pain or burning with urination
- Itching or irritation of the genitals
- Sores, blisters, or bumps on the genitals
- Rashes, including rashes on the palms of hands and soles of feet
- Pelvic pain

It is important to remember that the symptoms associated with STIs and other RTIs can vary from none to minor to severe. You cannot always tell if a person has an STI, and people without symptoms often transmit the infection to others unknowingly.

STIs and other RTIs can lead to serious complications, including infertility, chronic pain, and even death, especially if they are not detected and treated early. No cure exists for HIV infection or AIDS, and infection usually results in death. STI infection significantly increases the risk of acquiring or transmitting HIV.

## Appendix D

### Seriousness of STI/RTI Complications

Millions of men, women, and children all over the world are affected by the long-term complications of STIs and RTIs.

These infections can lead to numerous serious, long-term, and sometimes deadly complications, particularly in women. Some STIs/RTIs can also lead to pregnancy-related complications or congenital infections. Unfortunately, symptoms and signs of many infections may not appear until it is too late to prevent serious consequences and damage to the reproductive organs.

Even curable STIs can cause serious complications if left untreated. If they are not diagnosed and treated in time, some of these infections can cause infertility, chronic pelvic pain, premature labor and delivery, spontaneous abortion, ectopic pregnancy, inflammation of the testicles, cardiovascular or neurological complications, or even death. Some infections can also lead to pneumonia, respiratory infections, and eye infections in infants.

In addition, the complications of STIs and RTIs affect even more than an individual's health. The morbidity associated with them has a profoundly adverse effect on the quality of life and economic productivity of many women and men, their families, and, consequently, entire communities.

Some of the most common complications of STIs/RTIs include:

- Pelvic inflammatory disease (PID), which can lead to ectopic pregnancy, infertility, and chronic pelvic pain
- Increased susceptibility to opportunistic infections
- Infertility, early labor and delivery, stillbirth, and spontaneous abortion
- Neurological, cardiovascular, and other systemic conditions
- Chronic pain and discomfort

PID is an infection of the internal reproductive organs in women, involving inflammation, irritation, and swelling of the uterus (womb), fallopian tubes, ovaries, and surrounding pelvic tissues. PID is caused by STIs (most commonly chlamydia and gonorrhea) that have been left untreated. Other types of bacteria may also play a role in the disease.

The primary symptom of PID is lower abdominal (pelvic) pain. In mild cases, women may have no symptoms or may experience only slight cramping. In severe cases, the pain may be constant and very intense. Physical activity, and especially sexual intercourse, may greatly increase the pain.

Other symptoms of PID include:

- Abnormal vaginal discharge
- Abnormal or heavy vaginal bleeding
- Bleeding between periods
- Fever and chills
- Nausea and vomiting

PID, the most serious infection of the reproductive tract in women, can lead to infertility and chronic pelvic pain. PID can also place women at increased risk for *ectopic pregnancy* (a pregnancy that occurs outside the uterus, most commonly in the fallopian tubes), which can lead to life-threatening complications. If a client who has PID is pregnant at the time of diagnosis, it may be necessary for her to receive treatment in a hospital. If she becomes pregnant after acquiring PID, it is important to make sure early on that the pregnancy is not ectopic.

### Why Should Reproductive Health Services Focus on STIs and RTIs?

STIs and other RTIs are a rapidly growing problem throughout the world. Although the impact of STIs is serious in both developed and developing countries, it is most profound in the developing world:

- Every year, approximately 400 million adults worldwide become infected with an STI.
- In the year 2000, approximately 5.3 million people (including 600,000 children under the age of 15) were infected with HIV.
- As of November 2000, an estimated 36.1 million adults and children worldwide are living with AIDS or HIV infection, and 25.3 million of these are in Sub-Saharan Africa.
- In some developing countries, STI prevalence rates of 5% to 52% have been reported among women attending antenatal and family planning clinics.
- Today, STIs and other RTIs are among the most common problems for which people in the developing world seek health care services.

The human costs of HIV and other STIs are incalculable. Premature deaths and disabilities not only devastate families, but also threaten the cultural and economic stability of communities, countries, and whole continents.

### Links to HIV/AIDS

STI treatment and prevention can be an important tool in limiting the spread of HIV infection, since:

- A person with an STI has a much higher risk for *acquiring* HIV from an infected partner
- A person infected with both HIV and another STI has a much higher risk for transmitting HIV to an uninfected partner

For example, a person who has chancroid, chlamydia, gonorrhea, syphilis, or trichomonas infection can have as much as nine times the risk for getting HIV from a sexual partner as a person who is not infected with one of these STIs. An ulcerative STI (such as genital herpes, syphilis, or chancroid) increases the risk for HIV transmission per exposure significantly more than a nonulcerative STI (such as gonorrhea or chlamydia), since HIV can pass more easily through genital ulcers. But STIs that do not cause ulcers also increase risk, because they increase the number of white blood cells (which have receptor sites for HIV) in the genital tract and because genital inflammation may result in damage that can allow HIV to enter the body more easily.

In addition, HIV infection may complicate the diagnosis and treatment of other STIs, because HIV may change the patterns of disease or clinical manifestations of certain infections and may

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affect laboratory tests. In people with HIV infection, STI symptoms may be more severe, the period of infectivity may be increased, and normal treatments may fail.

### Family Planning Methods and STIs/RTIs

Contraceptive methods other than male or female condoms are not effective against the transmission of STIs, including HIV. While spermicides and barrier methods, such as the diaphragm, may offer some increased protection against bacterial STIs (e.g., against gonorrhea or chlamydia), the level of protection is fairly low.

Recent research results indicate that women who use some hormonal contraceptives (oral contraceptives or Depo-Provera) have an increased risk for contracting some STIs or RTIs, but a decreased risk for contracting others. For example, women using oral contraceptives were at increased risk for chlamydia and vaginal yeast infections, but at decreased risk for bacterial vaginosis, relative to women not using family planning. This altered susceptibility to STIs could influence the transmission of HIV. There has also been some concern about the possibility that hormonal contraceptives might increase women's susceptibility to HIV as a result of endometrial, cervical mucus, or bleeding changes that can occur when these methods are used. Some evidence suggests that methods with higher levels of progestins may increase risk; however, other studies have found mixed results. Additional research on this topic is needed.

Women who use hormonal methods are less likely to use condoms, so it is important to target these women with counseling messages promoting dual protection (i.e., hormonal methods for pregnancy prevention and condom use for disease prevention).

Intrauterine devices (IUDs) have been considered an inappropriate method for women at risk for STIs because of concerns about the potentially increased risk for PID following IUD insertion in women with cervical infections (gonorrhea, chlamydia, or both). The risks associated with IUD use may have been overstated in the past. Based on current evidence, it appears that PID rates associated with IUD insertion in women with cervical infections fall within or below the range of rates reported in infected women who do not have an IUD inserted. There is an inherent risk for PID in women who have an STI, even if they do not have an IUD inserted.

The level of risk for PID depends on the prevalence of gonorrhea and chlamydia in the population seeking family planning. In many settings, the prevalence is low. Symptomatic PID caused by IUD use is actually quite uncommon, even where STI prevalence is quite high. The vast majority of women with cervical infection who receive an IUD do not develop PID. Asking screening questions related to STI risk could greatly reduce risk by screening out a high percentage of those likely to be infected. IUD use may be unnecessarily restricted in many settings.

### No Missed Opportunities

Because STIs and other RTIs are a widespread global problem, it is important for health care providers to take advantage of all opportunities to communicate prevention messages. In addition to discussing STI and RTI prevention with clients, providers can address clients' concerns and answer clients' questions.

For many women, family planning and antenatal care visits are their only contact with the health care system and are the only opportunity for them to receive information about the prevention of and the potential impact of HIV, other STIs, and RTIs on their sexual and reproductive health.

### Special Concerns for Women

Although STIs affect both women and men, research shows that women are more susceptible to infection and are less likely to seek treatment than are men. The potential complications of untreated RTIs are more serious in women, and infections can be transmitted to the offspring of pregnant women as well.

Although infection rates vary tremendously among and within countries, the World Bank reports that STIs are the second most important cause of healthy life-years lost among women of childbearing age (after pregnancy-related problems). It is important to recognize that biologically, women are more vulnerable to diseases of the genital tract than are men, since:

- The lining of the vagina is a mucous membrane more permeable to infection than the skin on the outside of the penis
- Women's genitals have more surface area through which infection can occur
- Lack of lubrication during intercourse or changes in the cervix during the menstrual cycle can facilitate more efficient transmission of infection to women
- Younger women are particularly vulnerable because their cervical tissues may be less mature and more readily penetrated by organisms such as chlamydia and gonococcus
- Older women are more likely to get small abrasions in the vagina during sexual activity because of the thinning of the tissues and dryness that occur with age

Women who already have an infection (particularly one that causes genital lesions) are more likely to get or transmit HIV, and since women are often asymptomatic when they become infected with an STI, they often are not aware of this increased risk.

Other risks for women include the use of vaginal douches (which increase the risk for PID) and the influence of hormonal contraceptives on acquiring or transmitting STIs, although this relationship is not yet fully understood.

Many women are at risk for infection, particularly when their primary partners have other partners. Social and economic vulnerability amplify women's risk for infection. For example, many women lack the economic resources to live by themselves and are fearful of their male partner's abandonment or violence. Therefore, they have little control over how and when they have sex, which in turn hampers their ability to protect themselves from infection.

### Common STIs and RTIs

Any individual can become infected with an STI or an RTI, regardless of age, background, or socioeconomic class. The World Health Organization (WHO) estimates that there are more than 340 million new cases of curable STIs each year, and UNAIDS calculates that in 2000 alone, 5.3 million people became infected with HIV. RTIs that are not sexually transmitted are even more common.

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The STIs and RTIs that providers are most likely to encounter during client visits include the following:

- Bacterial vaginosis—An RTI in women caused by an upset of the vagina’s normal environment and overgrowth of bacteria in the vagina
- Chancroid—An STI that causes swelling of the lymph nodes and painful ulcers in the genital area
- Chlamydia—An STI in both men and women that often is asymptomatic
- Genital herpes—An STI that causes painful genital ulcers
- Genital warts, or human papillomavirus (HPV)—Bumps in the genital area caused by some forms of HPV (Other types of HPV can lead to cervical cancer.)
- Gonorrhea—An STI that can cause infertility in both men and women
- Hepatitis B—A virus that can cause liver damage and possibly even liver failure
- Hepatitis C—A virus that can cause liver damage and possibly even liver failure
- HIV infection—A retrovirus that weakens the immune system and causes AIDS
- Syphilis—An STI that initially causes sores that will heal on their own but that if left untreated can cause serious complications or even death
- Trichomonas infection—An STI in both men and women that is often asymptomatic
- Vaginal yeast infection—An RTI in women that occurs when the normal environment in the vagina changes

*Note:* Nongonococcal urethritis (NGU) is a term used to describe discharge from the penis that is *not* due to gonorrhea. It is usually caused by chlamydia and sometimes by trichomonas infection.

Less common STIs and RTIs include:

- Cytomegalovirus (CMV)—A common virus (a member of the herpes family) that can cause serious infections in people with compromised immune systems and can be transmitted sexually
- Donovanosis—An STI that can cause serious ulcers at the site of infection, ulcers that can grow together and cause permanent scarring and genital destruction
- Lymphogranuloma venereum (LGV)—An STI that causes inflammation of and prevents drainage of the lymph nodes in the genital area, and that can cause destruction and scarring of surrounding tissue
- Molluscum contagiosum—An STI that causes relatively benign skin infections and that can lead to secondary bacterial infections

## Signs and Symptoms of Common STIs and RTIs

To effectively manage STIs and RTIs, health care providers must be able to recognize the various signs and symptoms of infection. However, different infectious agents can cause very similar symptoms.

The following list identifies signs and symptoms of the most common STIs and RTIs:

### *In men*

- Urethral discharge—chlamydia, gonorrhea, trichomonas infection
- Urethral itching—chlamydia, gonorrhea, trichomonas infection
- Swollen or painful testicles—chlamydia, gonorrhea

### *In women*

- Unusual vaginal discharge—bacterial vaginosis, chlamydia, gonorrhea, trichomonas infection, vaginal yeast infection
- Genital itching—bacterial vaginosis, trichomonas infection, vaginal yeast infection
- Abnormal or heavy vaginal bleeding—chlamydia, gonorrhea  
(*Note:* This symptom is often caused by factors other than STIs.)
- Bleeding after intercourse—chlamydia, gonorrhea
- Lower abdominal pain (pain below the belly button or pelvic pain)—chlamydia, gonorrhea
- Persistent vaginal yeast infections—HIV/AIDS

### *In men or women*

- Blisters or ulcers (sores) on the mouth, lips, genitals, anus, or surrounding areas—chancroid, genital herpes, syphilis
- Burning or pain during urination—chlamydia, genital herpes, trichomonas infection, gonorrhea
- Itching or tingling in the genital area—genital herpes
- Jaundice (yellowing of the eyes and skin) or fever, headache, muscle ache, dark urine—hepatitis B, hepatitis C
- Warts or bumps on the genitals, anus, or surrounding areas—HPV (genital warts)

The following list identifies symptoms of some of the less common STIs and RTIs:

- Flu-like syndromes (fever, fatigue, headaches, and muscle aches), mild liver inflammation—CMV
- Small, dimpled bumps or lesions on the skin that usually do not hurt or itch and are flesh colored, but can vary from white to yellow to pink—molluscum contagiosum
- Small, red bumps or ulcers in the genital or anal area, or lymph node swelling in the genital area, or chronic ulcers on the genitals or anus—LGV
- Red nodules or bumps under the skin on the mouth, genitals, or anus that ulcerate, become tender, and often bleed easily—donovanosis

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### Asymptomatic Infections

Some STIs (for example, chlamydia, gonorrhea, HPV, hepatitis B, and genital herpes) often cause infections that are *asymptomatic*. This means that although the person has an infection, he or she has no symptoms of infection and thus may not realize that he or she is infected.

For example, some studies have shown that gonorrhea is asymptomatic in as many as 50% to 70% and chlamydia in as many as 80% to 90% of infected women. Additionally, the majority of HPV infections in women and men cannot be recognized clinically, and up to 75% of primary episodes (i.e., initial infections) of herpes are asymptomatic or produce only mild or unrecognized symptoms.

With asymptomatic infections, there is no evidence of infection on clinical exam; therefore, these infections can be diagnosed using laboratory tests only—a particular problem in parts of the developing world where testing resources are scarce or nonexistent.

Asymptomatic infections can be transmitted to others and can cause serious complications, particularly for women. For example, if left untreated, some infections can lead to PID and infertility in women. Therefore, it is critically important to test or treat female sexual partners of symptomatic men whenever possible, even if they show no signs and symptoms of infection.

### Safer Sex

*Safer sex* refers to practices that allow couples to reduce their sexual health risks and lower the likelihood of STI transmission. Generally, safer sex practices prevent contact with genital sores and prevent the exchange of body fluids, such as semen, blood, and vaginal secretions.

While some use the term *safe sex*, here we use the word “safer” in recognition of the fact that all sexual practices can have consequences—whether in terms of emotional consequences or in terms of disease and pregnancy—and that very few practices are without any risk of infection transmission.

*Remember: RTIs* refer to all infections of the reproductive tract, including STIs. *STIs* refer to infections transmitted primarily through sexual contact, including HIV infection.

### Critical Components of STI and RTI Management

The objectives of STI and RTI management are to diagnose the infection, treat it, encourage change in sexual behaviors and other risk-reduction strategies, and ensure that sexual partners are appropriately treated. High-quality management of STIs is important because it:

- Prevents the development of long-term complications
- Reduces the length of time during which a person is infected, and therefore reduces the further spread of STIs
- Reduces the level in the population of STIs that present an increased risk for sexual transmission of HIV
- Allows for education and counseling on risk reduction and health-seeking behaviors
- Generally improves the quality of people’s lives

Management of STIs and RTIs involves more than simply diagnosis and treatment of the infection. It also consists of:

- *Counseling and education.* Client-centered counseling helps prevent the spread of infection and reduce clients' risk of infection and reinfection. Counseling and education also provide clients with information on potential complications, as well as strategies to change risky sexual behaviors.
- *Condom promotion.* Demonstration or instruction in the correct use of condoms and access to an adequate supply of condoms are essential parts of STI management. Programs should help clients understand the importance of consistent and correct condom use and the steps of proper condom use, as well as help them develop skills for negotiating condom use.
- *Adherence with treatment.* Providers must educate clients about the importance of following and completing treatment regimens, even after all symptoms have disappeared. Providers should explore ways that clients can successfully adhere to treatment regimens by identifying potential barriers to adherence (e.g., costs, schedule, or family or partner finding out) and strategize ways to overcome these barriers.
- *Partner notification.* When feasible, sexual partners of clients with STIs should be notified and encouraged to seek appropriate care. (However, strict confidentiality is critical, and issues of domestic violence or potential harm to the client must also be addressed.) Treating partners prevents the further spread of the infection and reinfection of the client. There are three options for notifying partners:
  - Clients can be counseled about talking to their partners on their own
  - Providers can tell partners in conjunction with clients
  - If resources permit, providers or public health workers can inform partners

These four components are sometimes referred to as the “Four Cs”:

1. Counseling and education
2. Condom promotion
3. Compliance with treatment
4. Contacting partners

*Note:* The preceding material is adapted from: EngenderHealth, 2003g.

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### What Are HIV and AIDS?

**HIV**, which stands for *human immunodeficiency virus*, is the virus that causes AIDS. HIV destroys certain types of blood cells (known as *T-cells* or *CD4 cells*) that help the body fight off infection.

A person can be infected with HIV for many years before any symptoms occur, and during this time an infected person can unknowingly pass the infection on to others. HIV can be transmitted through some forms of sexual contact, through contact with infected blood and other body fluids (such as during the shared use of injection needles, through the use of contaminated skin-cutting tools, by means of needlestick injuries in health care settings, or via transfusions of infected blood), and through mother-to-child transmission during pregnancy, delivery, or breastfeeding.

**AIDS** is *acquired immunodeficiency syndrome*, an advanced stage of HIV infection that occurs when the immune system cannot fight off infections that the body is normally able to withstand. At this stage, the infected person becomes more susceptible to a variety of infections, known as *opportunistic infections*, and other conditions (e.g., cancer). Some examples include chronic cryptosporida diarrhea, cytomegalovirus eye infection, invasive cervical cancer, Kaposi's sarcoma, lymphoma, mycobacterium avium complex, pneumocystis pneumonia, toxoplasmosis, and tuberculosis.

At present, there is no cure for AIDS, and it is believed that most people with HIV infection will eventually die from an AIDS-related illness. However, with advances in HIV/AIDS therapies, including those that fight the virus itself as well as those that prevent or treat opportunistic infections, the lives of some people with HIV or AIDS—mostly in developed countries—have been dramatically extended and improved. Unfortunately, these therapies are rarely available in resource-poor countries, where the majority of those with HIV or AIDS live.

### How HIV Is Transmitted

HIV is spread through three main modes. These modes of transmission are as a result of exposure to body fluids (blood, semen, vaginal fluids, and breast milk) of infected individuals. Specifically, HIV can be transmitted through:

1. Sexual contact:

- Vaginal sex
- Anal sex
- Oral sex

2. Blood contact:

- Injections or needles (sharing needles, intravenous drugs, and drug paraphenalia, or suffering an injury from contaminated needles or other sharp objects)
- Cutting tools (using contaminated skin-piercing instruments, such as scalpels, needles, razor blades, tattoo needles, or circumcision instruments)
- Transfusions (receiving infected blood or blood products) or transplants using infected organs
- Contact with broken skin (exposure to blood through cuts or lesions)

### 3. Mother-to-child transmission:

- Pregnancy
- Delivery
- Breastfeeding

Although any exposure through one of these methods can lead to HIV infection, not every exposure results in transmission of the infection.

### How HIV Is *Not* Transmitted

Many myths exist about how HIV is transmitted, and many myths are culturally specific. It is important that people realize that HIV is actually quite difficult to transmit. It is far less transmissible than hepatitis B or some other STIs, for example. HIV is *not* transmitted by:

- Having ordinary social or casual contact
- Donating blood
- Sharing clothing
- Touching
- Sharing food or dishes
- Dry kissing
- Shaking hands
- Having contact with toilet seats
- Experiencing insect bites
- Massaging another person
- Sexually stimulating a partner using your hand (although a risk may exist if blood, semen, or vaginal fluids come in contact with broken skin)
- Masturbating
- Living with a person with HIV

In addition, HIV is not transmitted through tears, sweat, saliva, vomit, feces, or urine. Although these substances can contain HIV, they do not contain the virus in amounts significant enough to cause infection. Extensive, continuing studies of new HIV infections over the last 20 years in many countries have not uncovered any cases of infection through these substances. To date, there is no documentation of HIV transmission via these substances. Blood, semen, vaginal secretions, and breast milk are the only body fluids through which HIV transmission has been documented.

It is theoretically possible to transmit the virus through deep kissing if the gums have open sores or are bleeding, but this is highly unlikely. Even so, transmission in this case would be through blood rather than through saliva.

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### Modes of Transmission

#### Transmission through Sexual Contact

One of the most common ways in which HIV is transmitted is through sexual contact, primarily through unprotected vaginal or anal intercourse. In every act of sexual penetration, there is an inserter and a receiver. The receiver is generally at greater risk than the inserter, although if the penis of the inserter has open cuts, sores, or ulcers, then the inserter's risk is increased.

Unprotected anal sex (penetration of the anus by the penis) between two men or between a man and a woman is particularly risky because the chance of damage (small tears and lesions) to the thin lining of the rectum is high. This facilitates HIV transmission by enabling the virus in semen to quickly enter the bloodstream.

With penile-vaginal sex, the female partner is generally at higher risk because of the greater exposed surface area in the female genital tract than in the male genital tract, the higher concentrations of HIV in seminal fluids than in vaginal fluids, and the larger amount of semen than vaginal fluids exchanged during intercourse.

Although HIV transmission can occur through unprotected oral sex—cunnilingus (oral-vulval contact) or fellatio (oral-penile contact)—the risk is much lower than for unprotected vaginal or anal sex. But this behavior is not free of risk: With oral sex, the person at greater risk is the one using his or her mouth to stimulate the other person's genitals. The risk is increased when that person has open sores in the mouth or bleeding gums. The risk is also increased when that person receives semen in the mouth or swallows any secretions.

HIV transmission has also been reported through infected semen used for artificial insemination. Reputable sperm banks now test all samples before using them.

*Remember:* If both partners in a relationship know that they are not infected and they are monogamous (which is difficult to know), there is *no* risk of HIV transmission during unprotected sex.

#### Transmission through Blood and Blood Products

##### *Sharing Injection Drug Works*

The sharing of HIV-contaminated needles, syringes, drugs, and other drug paraphernalia can transmit HIV. Even if syringes and needles are sterile, drugs that are mixed in containers (including spoons or bottle caps) and are shared or drugs that are shared from a common container make for very risky injections.

While intravenous injections hold the greatest risk for infection, it is possible to be infected from subcutaneous and intramuscular injections as well. In many countries, injectable medications, syringes, and needles are available to the general public without a prescription. If multiple people use these, the risk for HIV transmission will increase.

##### *Transfusions and Organ Transplants*

Transfusions or treatments with infected blood or blood products can lead to HIV transmission. Many parts of the world now routinely test donated blood for HIV before approving its use, but

some countries lack the resources to do so. Organs or tissues taken from individuals with HIV can also transmit the virus to the people receiving them.

### ***Sharing Skin-Cutting or Skin-Piercing Tools***

HIV can be transmitted by skin-piercing, skin-cutting, and tattooing instruments (needles, razor blades, or circumcision instruments) that have been in contact with infected blood or body fluids and have not been properly processed before reuse.

### ***Transmission in Health Care Settings***

Health care workers, including cleaners and lab technicians, are at risk for becoming infected with HIV if they are exposed to blood and other body fluids of infected individuals during their work.

One type of exposure among workers in health care settings is needlestick injuries with HIV-contaminated needles. The risk for HIV transmission to clients during clinical or surgical procedures exists when clients are exposed to blood or body fluids containing HIV from other clients.

Following appropriate infection prevention practices can drastically reduce the risk for occupational exposure and HIV transmission to clients. The best way to prevent infections at a health facility is by following standard precautions. These are a set of recommendations designed to help minimize the risk for both clients and staff being exposed to infectious materials.

Providers should follow standard precautions with every client, regardless of whether they believe the client might have an infection. This is important because it is impossible to tell whether someone is infected with HIV, and often the infected persons themselves do not know that they are infected. (For detailed information on infection prevention in health care settings, see EngenderHealth, 2003e.)

*Remember:* It is safer to act as if every client is infected, rather than to apply standard precautions to some clients and not others.

### **Mother-to-Child Transmission**

A woman infected with HIV can pass the virus to her baby during pregnancy, labor and delivery, or through breastfeeding.

Roughly 15% to 30% of newborns of untreated HIV-positive women will become infected with HIV during pregnancy and delivery, and an additional 10% to 20% will become infected during breastfeeding. The risk varies by region, with transmission rates of 15% to 25% in the industrialized countries of Western Europe and in the United States, but rates of 25% to 35% in developing countries. Some studies have found rates as high as 43% in Sub-Saharan Africa. These rates represent the risk for transmission without preventive intervention. Treatment options that can greatly reduce the rate of HIV transmission from mother to child are now available in some settings.

The risk for HIV transmission through breastfeeding, which has been estimated to be between 10% and 20%, increases with a longer duration of breastfeeding. This risk appears to be great-

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est in the first few months of life and is lower among infants who are fed breast milk exclusively (exclusive breastfeeding) than among those who are breastfed and also receive supplemental foods or liquids (mixed feeding). In a recent study in South Africa, babies who were exclusively breastfed were significantly less likely to have become infected in the first three months than were those fed both breast milk and other food.

The risk for HIV transmission from an individual woman to her child is affected by a variety of factors, including:

- *Stage of infection.* If a woman is further along in her infection, she has a higher viral load and is more likely to transmit the virus to the child. Also, if she becomes infected during or just before pregnancy, the initial spike in viral load at the time of infection may increase the risk for mother-to-child transmission.
- *Breastfeeding pattern.* Exclusive breastfeeding has been found to present a decreased risk over mixed feeding, which is the norm in many countries.
- *Duration of breastfeeding.* Risk increases with the duration of breastfeeding.
- *Oral or breast lesions.* Lesions in the baby's mouth or on the mother's breasts increase the risk for transmission, because of the increased number of portals of entry for the virus.
- *Gastrointestinal illness.* When the virus is found in breast milk, a weakened gut may increase portals of entry in a baby who is breastfeeding.
- *Antiretroviral therapy.* This can significantly *reduce* the risk for mother-to-child transmission during pregnancy and labor and delivery.
- *Cesarean section.* This can significantly *reduce* the risk for mother-to-child transmission, but it is not necessarily realistic in resource-poor settings because of its technical demands and cost.
- *Invasive procedures.* Avoidance of invasive procedures during delivery can significantly *reduce* the risk for mother-to-child transmission.

It is important to note that all children born to HIV-positive women will test positive for HIV antibodies at birth, regardless of whether they are actually infected. This is because of the presence of the mothers' antibodies in the children's blood. Antibody testing can accurately determine infection after the age of 18 months.

### **Facts about Mother-to-Child Transmission**

- The risk for HIV transmission is estimated at 5% to 10% during pregnancy, at 10% to 20% during labor and delivery, and at 10% to 20% during breastfeeding.
- When no preventive measures are taken, the overall risk for transmission among women with HIV is estimated at approximately 15% to 35%.
- The risk for transmission increases if a woman becomes infected or is reinfected with HIV during pregnancy or while breastfeeding, or if she develops AIDS, because of the higher viral loads. Viral, bacterial, or parasitic placental infections may also increase the risk for transmission.
- If a woman becomes infected with HIV while breastfeeding, the risk for mother-to-child transmission will increase.

*Note:* More information on mother-to-child transmission and interventions appears in the "Preventing HIV Transmission" module of EngenderHealth, 2003d.

## HIV Risk and Vulnerability

A variety of demographic, behavioral, and social factors place people at risk for becoming infected with HIV and other STIs. Traditionally cited risk factors include, for example, age, multiple sexual partners, partners with multiple sexual partners, a history of STIs, and drug and alcohol use. Early in the AIDS epidemic, there was a tendency to refer to “high-risk groups”—those groups of people who have historically contracted the infection in large numbers. This often included, for example, sex workers and homosexuals. These types of categorizations may lead some people to assume that they are not at risk for infection if they do not belong to these groups.

### Risk “Behaviors,” Not Risk “Groups”

Over time, experience has taught that risk is not based on *who you are*, but rather on *what you do*. The idea of risk behaviors is that HIV and AIDS do not discriminate. Anyone who engages in a behavior that exposes himself or herself to HIV is at risk for infection. This includes:

- Anyone of any age who engages in unprotected vaginal, oral, or anal intercourse with anyone other than an uninfected, mutually monogamous partner
- Anyone whose partner engages in unprotected intercourse with others
- Drug users who share needles and other drug works
- Anyone who receives an injection with a potentially contaminated needle or syringe
- The sexual partner(s) of an injection drug user
- Recipients of transfusions or those treated with blood or blood products in regions where reliable screening of the blood supply does not occur
- Anyone who uses potentially contaminated tattoo needles or other skin-piercing instruments
- Any workers or clients at health care facilities who come in contact with blood, blood products, unclean needles, or surgical instruments
- A fetus or nursing child of a mother who is infected with HIV

This understanding, along with the experience that identifying groups of people as “high risk” leads to unjust stigma and discrimination, has led to a shift in the language from “risk groups” to “risk behaviors.” The distinction between risk groups and risk behaviors is important.

### Vulnerability

More recently, there has been a growing recognition that in addition to individual behaviors or characteristics, certain social, economic, and political forces make people or groups of people vulnerable to infection. In a sense, HIV and AIDS *do* discriminate. Some factors that affect social vulnerability include gender inequalities, economic power, youth, cultural constructs, and government policies. The following sections consider the particular vulnerabilities of women, men, and children and youth.

### Women’s Vulnerability and Risk

The number of women living with HIV and AIDS has been steadily increasing over the past decade. AIDS now ranks as one of the leading causes of death for women between the ages of 20 and 40 in parts of Europe, North America, and Sub-Saharan Africa. In Sub-Saharan Africa, infection rates among women have now surpassed those among men: Women now account for

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55% of all infections, and rates of infection among pregnant women are extremely high in many countries. Women are vulnerable to infection for biological, social, and economic reasons.

Women may be particularly vulnerable to infection because of gender inequalities and lack of power within sexual relationships, which make it difficult, if not impossible, for them to negotiate safer sex with partners. Lack of economic power can lead to vulnerability as some women are forced to enter into sex work or to form temporary partnerships to barter sex for economic survival. Furthermore, because of women's greater biological vulnerability to infection transmission, they face greater risk for infection.

Biologically, the risk for transmission from male to female is greater than the risk from female to male, for several reasons. These include:

- There is a more exposed surface area in the female genital tract than in the male genital tract.
- HIV is in higher concentrations in semen than in vaginal fluids.
- More semen than vaginal fluid is exchanged during intercourse.
- Coercive or forced sex might lead to microlesions in the genital tract that facilitate entry of the virus.
- Traditional practices such as female genital cutting can expose women to risk if the cutting instruments are not properly cleaned.
- Women often have STIs that are left untreated, which increases their vulnerability to HIV.

All over the world, social factors stemming from gender inequalities also make women particularly vulnerable to HIV infection caused not by their own behavior, but by that of their partner. These factors include that:

- Women are often expected to remain monogamous, yet being married often places them at high risk for infection (because men are not often expected to be monogamous, and in some cases, are even encouraged to have multiple partners).
- Women lack the social power to reduce their risk for infection.
- The threat of physical violence, the fear of abandonment, or the loss of economic support can act as significant barriers inhibiting women from negotiating condom use, discussing fidelity with their partners, or leaving relationships they perceive to be risky.
- Cultural norms often deny women knowledge of sexual health.
- When women possess knowledge of sexual health, society often considers it inappropriate for them to reveal this knowledge, making partner communication about risk and safety impossible.
- Women often have little control over their bodies and little decision-making power, with men making most decisions about when, where, and how to have sex.
- Social pressure to bear children may also affect women's choices concerning the relative importance of pregnancy versus protection from disease.
- Women are at greater risk than men for being raped, for being coerced into sex, or for being forced into sex work or sexual slavery.

Lack of economic power can also lead to vulnerability for several reasons, including that:

- Some women are forced to enter into sex work or multiple temporary partnerships so they can barter sex for economic gain or survival, including food, shelter, and safety.

- Many women are at risk simply because they are economically dependent on their husbands for survival and support, which limits their decision-making and negotiating power.
- Sex workers in general are at an extremely high risk for infection, particularly when they do not have the ability to negotiate with clients who refuse to wear a condom or when they are in settings where commercial sex work is illegal.

### **Risks for Men**

A variety of social factors also put men at risk for infection. Socially ingrained concepts of masculinity and common attitudes and behaviors can translate into risk behaviors that threaten men's health and the health of their partners.

For example, cultural norms of "masculinity" that expect men to be experienced and knowledgeable about sex may place men (particularly young men) at risk because they are less likely to seek information about risk reduction, for fear of admitting a lack of knowledge. Attitudes about masculinity encourage men to demonstrate sexual prowess by having multiple partners and by consuming alcohol or other substances that may contribute to risk-taking behavior. Men are often socialized to be self-reliant, to not show emotion, and to not seek assistance in times of need or stress—ideas that do not support men in protective or health-seeking behaviors. Men are also more likely to use injection drugs.

In many cultures, communities deny the existence of men who have sex with other men, which results in a lack of prevention, care, and health information directed to men who may be at risk. Discrimination and stigmatization against men who have sex with other men contribute to denial and secrecy, making it difficult to reach these men with HIV-prevention interventions.

To safeguard men's health and the health of their female partners and their children, health care services and providers must address the relationship between men's behavior and HIV transmission, to encourage men and boys to make a strong commitment to preventing the spread of the infection and to promote programs that respond to the needs of both men and women.

### **Risk and Vulnerability of Children and Youth**

AIDS is very much a disease of the young. Although comprehensive data are lacking, there is evidence that more children and young people younger than 18 are living with HIV and AIDS than ever before. UNAIDS and WHO estimate that more than 4 million children younger than 15 have been infected with HIV since the beginning of the epidemic, and that in 2000 alone, 500,000 children younger than 15 died an AIDS-related death.

The vast majority of infected children—well over 90%—live in developing-world countries; moreover, in the regions most affected by the epidemic, if current infection rates remain unchecked, AIDS may increase infant mortality by as much as 75% and mortality of children younger than 5 by more than 100%. HIV infection leads to AIDS and death much faster in children than in adults, and pediatric AIDS results in death more quickly in developing countries, because of widespread poverty, poor nutrition, and other contributing factors.

Most infected children younger than 14 acquire the virus from their mothers, either before or during birth or through breastfeeding. As more women of childbearing age have become infect-

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ed, the number of children infected has also risen. Aside from the risk for mother-to-child transmission, children and adolescents are also extremely vulnerable to infection through blood transmission, sex (including incest, other sexual abuse, and commercial exploitation), and injection drug use.

In many countries, the first consensual sexual experience occurs before age 18, and young people may not have the knowledge or experience to reduce their risk for exposure to HIV and AIDS. Adolescents may lack knowledge about pregnancy and about STI and HIV transmission, and they may be less likely to recognize potentially risky situations or to negotiate safer sex behaviors. In addition, peer pressure, drug and alcohol use, and other factors may increase adolescents' likelihood of engaging in high-risk behaviors.

Young people of both sexes are vulnerable to infection for many reasons, including social, biological, behavioral, and demographic factors. For example, young men often face tremendous pressure to be sexually active and are, therefore, less likely to seek information about how to protect themselves and their partners, for fear of appearing inexperienced. Young women, on the other hand, may be particularly vulnerable for biological reasons (for example, less mature tissues may be more readily permeated or damaged) and for social reasons, including lack of economic resources and negotiating power.

Young women are often forced into relationships with older men for economic survival, and anecdotal reports from some high-prevalence countries indicate that older men may seek younger women and girls for sexual relations, believing that they are less likely to be infected. Wide age disparities in infection rates substantiate these social patterns, with young women in many places having infection rates equal to those among men 10 years older.

### HIV Testing

The most frequently used HIV tests detect the presence of antibodies to HIV, not the actual virus. A positive HIV antibody test indicates the presence of antibodies to the virus, while a negative test result indicates either no antibodies or an undetectable level of them. It is possible that these tests can miss infection in a person who was recently infected with HIV and has not yet developed enough antibodies to show a positive result.

The period of time from infection with HIV until the body has developed detectable antibody levels is called the *window period*. The window period is approximately three months long, on average. A person who is worried that he or she may have been exposed to infection should be encouraged to seek testing, and the counselor should explain that if the test comes back negative, it should be repeated after three months to confirm the result, since the person could have been infected but still may be in the window period. During this period, a person may not test positive even if he or she is infected with HIV.

### Rationale for Testing

HIV testing should always be done voluntarily and should never be mandated or coerced. People who desire to know whether they are infected have a right to know. It is strongly recommended that clients be counseled both before and after testing. Where testing is readily avail-

able, a person who thinks that he or she might have been exposed to HIV should consider being tested for a number of reasons:

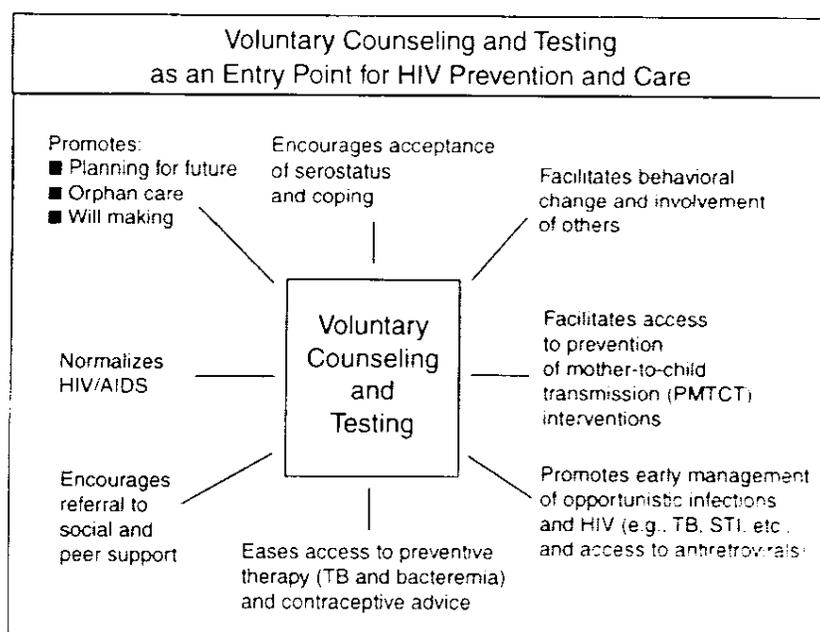
- A person who knows that he or she is HIV-infected can take steps to avoid transmitting the infection to others.
- In settings where medications are available to combat opportunistic infections and keep people healthy longer, it is best for people to know they are infected as soon as possible, so they can begin treatment and schedule regular checkups right away.
- Women who know that they are infected can make informed decisions about family planning, pregnancy, and breastfeeding. In some settings, treatment can greatly reduce a pregnant woman's risk for transmitting HIV to her child.
- Some people want to know their HIV status so that if they are infected with HIV, they can make lifestyle changes that will preserve their health to live longer or better lives.

HIV counseling and testing can be important decision-making tools for clients and service providers and can help even uninfected clients understand their risk for HIV. In addition, testing enables health care providers to offer information to infected clients about living with HIV infection and assist them in obtaining any available support services, including treatment, emotional and practical support, prevention of mother-to-child transmission, and legal services.

### Voluntary Counseling and Testing

Voluntary counseling and testing (VCT) is a combination of two activities—counseling and testing—into a single service that can amplify the benefits of both. In its ideal form, VCT can be used as a form of prevention rather than strictly for diagnostic purposes, or to facilitate entry into HIV care services.

The “gold standard” for VCT incorporates pretest counseling and posttest counseling. Helping clients understand and perceive their own risk (and the risks that their behavior may pose to others) and reduce that risk are integral components of the counseling in VCT.



Source: WHO, 1999.

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VCT is an important entry point for other HIV and AIDS services, which can benefit clients with either positive or negative test results. For example, clients with negative results can still be encouraged to adopt behaviors that may reduce their risk of being exposed to HIV and other STIs, making VCT an important strategy for prevention. When they are well implemented, VCT services offer the possibility of benefiting the community by “normalizing” the existence of HIV and AIDS—that is, reducing stigma and promoting awareness (see chart, page 233).

VCT is an essential component of programs intended to prevent mother-to-child transmission, because such programs cannot be implemented if women do not know their HIV status. Programs should not focus only on identifying HIV-positive women for intervention, however; they should also focus on reducing women’s risks and on helping those who test negative remain that way. VCT programs for pregnant women can benefit from men’s involvement: Some studies have shown that when women test positive for HIV and their male partners are not tested, the women are often blamed for introducing the infection into the couple. Such unfounded blame can lead to conflict, abandonment, and even violence.

*Note:* The preceding material is adapted from: EngenderHealth, 2003d.

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