

FN-ABW-104

A CURRICULUM PROTOTYPE

PARTICIPANT'S HANDBOOK

INCLUDES INFORMATION ON:

AIDS and other STDs

Sexuality

Counseling men, adolescents, postabortion women,
pregnant and postpartum women

Family Planning Counseling

A Curriculum Prototype

• *Participant's Handbook*

AVSC International

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Introduction

This book contains handouts that are used by participants during the course *Family Planning Counseling*. They may also be used as reference material after the participants return to their home institutions.

The handouts are numbered according to the module numbers within the curriculum. For instance, Handout 4-1 is the first handout for Module 4 “Factors in Client Decisions.” Note that Modules 1, 10, and 11 do not have handouts.

This material is intended to be used with the book *Talking with Clients about Family Planning: A Guide for Health Care Providers*, also published by AVSC International.

2-1: Rights of the Client

Every family planning client has the right to:

1. **Information:** To learn about the benefits and availability of family planning.
2. **Access:** To obtain services regardless of gender, creed, color, marital status, or location.
3. **Choice:** To decide freely whether to practice family planning and which method to use.
4. **Safety:** To be able to practice safe and effective family planning.
5. **Privacy:** To have a private environment during counseling or services.
6. **Confidentiality:** To be assured that any personal information will remain confidential.
7. **Dignity:** To be treated with courtesy, consideration, and attentiveness.
8. **Comfort:** To feel comfortable when receiving services.
9. **Continuity:** To receive contraceptive services and supplies for as long as needed.
10. **Opinion:** To express views on the services offered.

Adapted from: International Planned Parenthood Federation. *Rights of the client*. London: 1991.

2-2: Worksheet: Three Kinds of Family Planning Communication

Read each case. Decide whether it describes (M) motivation or promotion, (I) information-giving, or (C) counseling. Write the letter of your response on the line.

- ___ 1. A health care worker asks a woman who expresses interest in tubal ligation when she decided that she did not want more children.
- ___ 2. A maternity nurse tells a mother who has just delivered a baby that this is the right time to consider having her tubes tied so that she will not have to worry about becoming pregnant again.
- ___ 3. A doctor in a postpartum hospital ward discusses various family planning methods and tells how each one works.
- ___ 4. A social worker in a hospital tells a woman who is seeking an abortion that she needs to have an IUD inserted.
- ___ 5. A nurse meets with a woman who expresses concerns about irregular bleeding following an insertion of Norplant implants. The nurse reassures her that the bleeding is normal and will probably diminish over time.
- ___ 6. A doctor responds to a client's concern about vasectomy by explaining that the client's sexual ability will not be negatively affected by the operation.
- ___ 7. A field worker explains to his clients how to take the pill and what to do if they forget one.
- ___ 8. A doctor checks that a woman has reached an informed decision by reviewing with the client her reasons for wanting a tubal ligation.
- ___ 9. A nurse shows a film to women waiting for their prenatal visits and gives a brief talk about postpartum contraception.
- ___ 10. A supervisor in a factory tells male workers that they need to use condoms.
- ___ 11. A nurse talks to clients about Norplant implants, the IUD, and permanent methods only, since these are the most effective methods.

2-3: Personal Qualities Needed by Family Planning Counselors

- Desire to work with and help people
- Belief in the value of family planning
- Respect for people and for their right to make decisions for themselves
- Comfort with human sexuality
- Comfort with the expression of feelings
- Self-awareness of one's values and limitations
- Unbiased attitudes towards different population groups (for example, individuals of different age, ethnicity, religion, race, class, education, or gender)
- Tolerance for values that differ from one's own
- Empathy for clients
- Supportive attitude towards clients
- Ability to maintain confidentiality
- Unbiased attitudes towards various family planning methods
- Professionalism

2-4: Skills Needed by Family Planning Counselors

- Create a comfortable atmosphere for the client
- Present information clearly
- Encourage questions
- Listen and observe attentively
- Ask questions effectively to encourage the client to share information and feelings
- Guide the counselor-client interaction
- Speak the client's language

2-5: Knowledge Needed by Family Planning Counselors

- **About the clients:**
 - » Local culture, including fertility norms and sexual practices
 - » How clients reach decisions on family planning and the influences on those decisions
 - » Factors that may inhibit clients from asking questions or expressing their needs and concerns
 - » Signs that indicate the client may not be making a well-considered decision
 - » Factors inhibiting successful contraceptive use
 - » Special cases and circumstances and how to handle them

- **About contraception:**
 - » Reproductive anatomy and physiology
 - » Common misconceptions about family planning
 - » Contraceptive technology (benefits, risks, effectiveness, and methods of action for all available methods)
 - » Details of tubal ligation and vasectomy surgery, including anesthesia
 - » Instructions for clients about how to use each method correctly and safely
 - » What clients should do in the event of complications or side effects due to contraceptive methods
 - » How to prevent the spread of sexually transmitted diseases, including infection with the human immunodeficiency virus (HIV)

- **About family planning counseling:**
 - » Primary purpose of counseling: to help clients make informed, voluntary and well-considered decisions regarding fertility and contraception
 - » Importance of confidentiality
 - » Distinctions between counseling, information-giving, and motivation
 - » Responsibilities of a family planning counselor
 - » How to counsel clients considering tubal ligation or vasectomy, including documentation of informed consent

- **About the family planning program:**
 - » Policies and procedures of the family planning facility
 - » Client eligibility requirements for different methods
 - » Referral networks and procedures for family planning services and other reproductive health services
 - » Record-keeping requirements

- **About the country:**
 - » Government policies on family planning, including tubal ligation and vasectomy
 - » Laws regarding family planning, including tubal ligation and vasectomy

3-1: Values Clarification Worksheet

Read each statement. Decide whether you agree (A), disagree (D), or are undecided (U). Write the letter for your response on the line.

- ___ 1. If a woman wishes to have a tubal ligation, she should have one, even if her spouse disagrees.
- ___ 2. If a man wishes to have a vasectomy, he should have one, even if his spouse disagrees.
- ___ 3. Unmarried adolescents should not engage in sexual activity.
- ___ 4. A 21-year-old woman with only one child should be refused a tubal ligation.
- ___ 5. If a woman never experiences childbirth, she will feel like less of a woman.
- ___ 6. Most people with sexually transmitted diseases have had many sex partners.
- ___ 7. Schools should provide sex education.
- ___ 8. Some clients want to continue getting pregnant until they have children of both sexes. Providers should discourage this behavior.
- ___ 9. Family planning methods should be available to unmarried adolescents.
- ___ 10. In a couple, it is the woman who should be responsible for using contraception.

3-2: Who Is Responsible?

Roles:

Mrs. X

Mr. X

Dr. Y

Faduma W

Religious counselor

Emile

Scenes:

Mrs. X has brought three daughters into the world with much difficulty; she had to have a cesarean section each time.

Mr. X is a businessman, happy with his wife and three daughters. All he is missing is a son.

Dr. Y, Mrs. X's doctor, has warned her that a fourth pregnancy could be dangerous. Knowing that Mr. X wants a son, however, he does not want to perform a tubal ligation.

Mrs. X has stopped breast-feeding her youngest child and has asked her doctor to help her avoid becoming pregnant, or to guarantee her that her next pregnancy will be her last and to explain to her how to have a son. Dr. Y explains that it is the sperm of her husband that determines the sex of the baby. He sends Mrs. X to the family planning clinic.

Faduma W, the midwife in charge of family planning services, refuses to help Mrs. X without the knowledge of her husband.

Mrs. X goes to her religious counselor. He scolds her, telling her she is obliged to accept the will of God, and submit to her husband.

Remembering what Dr. Y said concerning the sperm, Mrs. X goes to see her cousin Emile, a handsome young man who has only sons. She proposes to him that they have sex so that she can have a son and her husband will agree to the tubal ligation.

Emile accepts. Mrs. X conceives and dies of a ruptured uterus at 38 weeks of pregnancy.

Who is responsible for this death? Mr. X? Mrs. X? Dr. Y? The midwife? The religious counselor? Emile? Or perhaps the baby?

Decide for yourself.

4-1: Basic Facts about Sexually Transmitted Diseases

It is important for family planning counselors to have a basic understanding of sexually transmitted diseases (STDs). Clients should consider their risk of getting an STD from their partner(s) or giving an STD to their partner(s), and the best way to provide protection in either case. Some contraceptive methods provide protection against STDs, and others do not. The information provided below is for the counselor who works in the family planning setting. This guide is not meant to be the basis for diagnosis or treatment of STDs.

This handout also provides some general information about reproductive tract infections (RTIs), since it is important for counselors to be aware of other infections that may not necessarily be caused by sexual contact. The term *reproductive tract infection* includes:

1. STDs, including HIV infection: Infections passed from person to person by sexual contact
2. Vaginal infections: Infections not caused by sexual contact, such as yeast or bacterial vaginosis
3. Infections caused by the provider, such as pelvic infection from inadequate infection prevention practice

What are STDs?

The term *sexually transmitted disease* refers to an infection that is passed from person to person by sexual contact. STDs are part of a broader group of infections known as reproductive tract infections. Some RTIs are not caused by sexual contact, but may be the result of an overgrowth of the bacteria and other organisms that normally live in the vagina. While some RTIs may cause only mild discomfort, others can be very serious. The presence of any infection that causes irritation of the skin in and around the vagina increases the possibility of infection with HIV, the virus that causes AIDS. Viruses can enter the body through damaged skin more easily than through healthy skin. For client comfort and safety, all infections should be treated.

When a client states that she or he has reproductive tract symptoms (pain, itching, swelling, sores, or discharge), the counselor should remember that not all infections of the genitals or reproductive tract are the result of sexual contact. Telling a client he or she has a sexually transmitted disease can have serious negative consequences for the client and his or her sexual partners. Before doing so, the counselor must be sure of the diagnosis.

Symptoms and diagnosis of RTIs, including STDs

Clients with symptoms of RTIs should be referred to a clinician as soon as possible. Clients without symptoms who report that they have been with a partner who complains of symptoms of an infection should also be referred for further evaluation. Almost half of all women who have RTIs do not complain of symptoms, either because they do not have any or because the symptoms are very mild and not terribly bothersome.

For women, unusual changes in the vagina or genital area may indicate the presence of an RTI. It is normal for a woman to have some vaginal discharge at all times. This normally clear or white discharge may change in amount at different times throughout her monthly cycle. If the discharge changes in color, has a bad odor, or is associated with itching, burning, or pain, the woman may have an RTI. An evaluation by a clinician is needed. If the woman is diagnosed with an STD, her sexual partner(s) will also need to be treated.

A man normally has no discharge from his penis except for the small amount of fluid that appears just before ejaculation (orgasm). If a man has a discharge at any other time or if he has pain or burning with urination or ejaculation, an evaluation by a clinician is needed. If the man is diagnosed with an STD, his sexual partner(s) will also need to be treated.

Common STDs

Several infections can be transmitted through sexual contact. Some of the most common ones are described here. HIV infection (which can lead to AIDS) is also a sexually transmitted infection. It is discussed in Handout 4-2.

GONORRHEA

The bacteria that causes gonorrhea grow in the warm, moist parts of the body, such as the urethra, the cervix, the rectum, and the throat (throat infection can occur following oral-genital sex with an infected partner).

SYMPTOMS: In women, symptoms include unusual vaginal discharge, burning during urination, or bleeding after intercourse or between periods. Many women with gonorrhea (perhaps more than half) have no noticeable signs or symptoms. Untreated gonorrhea may lead to pelvic infection with symptoms that include abdominal or lower back pain, pain with intercourse, bleeding between periods, and fever. Pelvic infection can be a very serious condition and requires immediate medical care.

In men, the symptoms of gonorrhea are a cloudy or pus-like discharge from the penis, pain or burning with urination, or swollen and tender testicles. Some men have no symptoms.

Gonorrhea infections in the rectum often have no symptoms, but gonorrhea in the throat may cause a sore throat.

RISKS: In women, gonorrhea can spread into the pelvic area and infect the uterus, fallopian tubes, and ovaries. This may cause enough damage to the women's reproductive organs that she can become sterile.

In men, gonorrhea can infect the epididymis, a structure where sperm are stored. This resultant epididymitis can lead to infertility.

Gonorrhea can be passed from mother to baby during birth, infecting the baby's eyes. Without prompt treatment, the infant's eyes can be seriously damaged.

CHLAMYDIA

SYMPTOMS: Women with Chlamydia often have no symptoms of infection. Some women notice an unusual vaginal discharge or bleeding after intercourse or between menstrual periods. Untreated Chlamydia may lead to pelvic infection with symptoms that include abdominal or lower back pain, pain with intercourse, bleeding between periods, and fever. Pelvic infection can be a very serious condition and requires immediate medical care.

Symptoms in men usually include a clear discharge from the penis and burning with urination or swollen and tender testicles. Some men have no symptoms.

The same bacteria that cause these symptoms (*Chlamydia trachomatis*) can also cause another group of symptoms called LGV (lymphogranuloma venereum). The symptoms in LGV include genital sores (ulcers) and swollen lymph nodes (bubos).

RISKS: In women, Chlamydia can spread into the pelvic area and infect the uterus, fallopian tubes, and ovaries. This may cause enough damage to the woman's reproductive organs that she can become sterile.

In men, Chlamydia can affect the testicles and also cause sterility.

Chlamydia can be passed from mother to baby during birth, infecting the baby's eyes. Without prompt treatment, the infant's eyes can be seriously damaged. *Chlamydia trachomatis* can also cause eye infections in children or adults, although this is not necessarily by sexual transmission.

SYPHILIS

SYMPTOMS: The first symptom of syphilis infection is usually a small painless sore in the area of sexual contact (penis, vagina, rectum, or mouth), which appears about three weeks after exposure and disappears within a few weeks. Shortly after the sore disappears, a rash, swollen lymph nodes, fever, or tiredness may be noticed, but these symptoms also disappear within a few weeks.

RISKS: Syphilis is a very serious disease for both men and women. It spreads through the whole body. Without the proper antibiotic treatment, the disease can cause mental illness, blindness, heart disease, and death.

Syphilis can be passed from mother to infant before birth, and an infected newborn may suffer from blindness, other severe organ damage, or death.

TRICHOMONAS

Trichomonas is a microscopic organism that can be sexually transmitted from person to person.

SYMPTOMS: Both men and women may be infected with Trichomonas, yet have no symptoms. Some people may carry the organism for months or years with no symptoms at all, or they may have had symptoms that have gone away.

Women who have symptoms may notice an unusual vaginal discharge or odor, and itching or soreness of the vulva.

Men who have symptoms may observe a discharge from the penis and burning with urination.

RISKS: Trichomonas itself is not known to lead to serious complications. However, recent evidence indicates that Trichomonas may be associated with early delivery in pregnant women. In addition, Trichomonas can cause irritation of the skin in and around the vagina, and the presence of damaged skin can increase the risk of HIV transmission.

PELVIC INFLAMMATORY DISEASE

Pelvic inflammatory disease (PID) is an infection of the internal female organs, usually affecting the uterus, one or both fallopian tubes, the ovaries, and surrounding pelvic tissues. These tissues become inflamed, irritated, and swollen. PID is caused by several types of bacteria and other microorganisms. Nearly half of all cases of PID are caused by gonorrhea; Chlamydia is the probable cause of a large percentage of PID cases. Both gonorrhea and Chlamydia are sexually transmitted.

SYMPTOMS: The primary symptom of PID is lower abdominal or pelvic pain. In mild cases, there may be only slight cramping, while in severe cases the pain may be intense. Physical activity, especially sexual intercourse, may greatly increase the pain. Abnormal vaginal bleeding (extremely heavy menstrual periods or bleeding or spotting between periods) is a very common symptom. Abnormal vaginal discharge and fever may also be present.

RISKS: The complications following PID can be very serious. They include:

1. **REPEAT PID:** Women who have had PID in the past are very likely to get it again.
2. **PELVIC ABSCESS:** This local collection of pus in the pelvis is formed by the breakdown of tissues. It is found in severe cases of PID. Pelvic abscess requires hospitalization and intravenous antibiotic treatment; it often requires surgery.
3. **INFERTILITY:** When PID heals, scar tissue can form around the pelvic organs. This scar tissue can cause blockage and distortion of the fallopian tubes. The result is that the egg cannot get through the tube and into the uterus. After one episode of PID, a woman has an estimated 15% chance of infertility. After two episodes, the risk of infertility increases to approximately 35%, and after three, the risk is nearly 75%.
4. **CHRONIC PELVIC PAIN:** Besides causing infertility, the scar tissue associated with PID may produce chronic pelvic pain or discomfort because of the distortion of the pelvic organs. Surgery may be required in severe cases.
5. **ECTOPIC PREGNANCY:** An ectopic pregnancy occurs outside the uterus, most commonly in the fallopian tubes. Because PID can cause partial blocking or distortion of the fallopian tubes, the chances of an ectopic pregnancy are greatly increased in a woman who has had PID. An ectopic pregnancy is a very serious condition and must be surgically removed.

OTHER STDs

There are many other infections that are sexually transmitted. Sores, growths, ulcers, or swollen lymph nodes in the genital area, and pain, burning, or vaginal irritation are common signs and symptoms of STDs and other RTIs and should be evaluated by a clinician. When clients complain of these symptoms, they may or may not have an STD, but they should see a clinician for evaluation as soon as possible.

RTIs that are not considered STDs

BACTERIAL VAGINOSIS

Bacterial vaginosis has been referred to by a number of different names (such as *Gardnerella* and *Hemophilus*). It is an overgrowth of a variety of normally occurring bacteria in the vagina, but the actual cause is unclear. Studies indicate that a woman with bacterial vaginosis has an increased chance of having a variety of other reproductive tract problems, so diagnosis and treatment are important.

SYMPTOMS: Bacterial vaginosis usually causes a vaginal discharge that is gray in color and has an unpleasant or fish-like odor. The discharge may not be accompanied by itching or irritation. Some women have no symptoms.

Men usually do not have symptoms of this infection. It is unclear if they carry the bacteria and if bacterial vaginosis is sexually transmitted.

RISKS: Bacterial vaginosis may increase a woman's chance of having other reproductive tract problems, such as other types of infections. It has also been associated with early delivery in pregnant women and low birth weight in newborns.

MONILIASIS (YEAST)

Other names used for moniliasis include *yeast* and *yeast infection*. Moniliasis is caused by an overgrowth of organisms that are often present in low numbers in the vagina. Pregnancy and taking antibiotics are among the things that can cause an overgrowth of these organisms, leading to irritation or itching in and around the outside of the vagina. Frequent exposure to semen over a short period of time can also cause moniliasis. Sometimes, but rarely, moniliasis can be passed sexually from person to person.

SYMPTOMS: In women, symptoms of moniliasis include vaginal itching, irritation, burning, and sometimes a white, thick discharge.

In men, moniliasis can appear as an itchy rash on the genitals.

RISKS: Moniliasis does not infect the uterus or fallopian tubes and does not affect a woman's ability to become pregnant. It may cause severe irritation, and because it damages the skin in and around the vagina, it should be treated. Some clients do not find it bothersome and do not require treatment.

4-2: Basic Facts about HIV Infection and AIDS

What is HIV?

HIV is *human immunodeficiency virus*, the organism that causes AIDS. A person can be infected with HIV and not know it. HIV is found in the body fluids (particularly blood, semen, and vaginal secretions) of infected persons. It is believed that most people infected with HIV will develop AIDS. **HIV can be transmitted whether symptoms of AIDS are present or not.** There are tests that tell people if they have been exposed to the virus. They do not tell people if or when they will get AIDS.

What is AIDS?

AIDS is *acquired immunodeficiency syndrome*, a condition caused by HIV, that attacks the immune system and makes it unable to fight disease and infection. A person can be infected with HIV and not know it. The symptoms of AIDS are listed on the next page. Even if the symptoms of AIDS subside for awhile, the virus that causes them is still present, and the infected person can still transmit the disease. AIDS is usually fatal. At present, there is no cure for AIDS.

How is HIV contracted?

HIV is contracted:

- through sexual contact (vaginal, anal, or oral intercourse) with an infected person. During intercourse, semen or vaginal fluids and sometimes blood come into contact with the penis, the thin lining of the vagina, the rectum, or the mouth. HIV in these fluids can then get into the blood stream. HIV can enter the blood through the vagina, penis, anus, open genital or oral sores, or cuts.
- through transfusions or treatments with infected blood products.
- through skin-piercing instruments that have been in contact with infected blood or body fluids and have not been properly disinfected (for example, needles, syringes, razor blades, or circumcision instruments).
- in infants, from an infected mother during pregnancy or childbirth. If the mother is infected with HIV, there appears to be a 15% to 30% chance that the newborn child will be infected. According to recent evidence, a breastfeeding child may have a higher risk of HIV infection through breast milk if the child's mother is initially infected with HIV while she is breastfeeding. There is also some risk of HIV transmission in breast milk if the woman has been infected before beginning breastfeeding. However, the risk of HIV infection of the child must be weighed against the risk of the child dying from other causes if it is **not** breastfed. Diarrheal

disease in young children, which can be fatal, is often attributed to lack of breastfeeding. If a woman is HIV positive, or suspects she is, and wishes to breastfeed, she should be encouraged to consult a doctor or nurse for advice.

How is HIV *not* contracted?

HIV is *not* contracted through any of the following:

- ordinary social contact
- shared clothing
- touching shared food or dishes
- kissing and hugging
- shaking hands
- toilet seats
- insect bites
- tears
- saliva
- sweat
- living with an infected person

What are the symptoms of HIV infection and AIDS?

Persons infected with HIV may be asymptomatic. It can take eight years or more between HIV infection and the diagnosis of AIDS. Once symptoms begin to develop, they may include:

- an unexplained loss of weight lasting at least one month
- diarrhea for several weeks
- a white coating on the tongue
- enlarged or sore glands in the neck and/or armpit
- a cough that persists for more than one month
- persistent fever
- persistent symptoms of vaginitis

Since these symptoms characterize other diseases (a persistent cough may be a symptom of tuberculosis; diarrhea may indicate an intestinal illness), a test must be done to confirm the presence of HIV.

Who is at risk?

Anyone can become infected with HIV, but only through the means described above. Clients who are at high risk include prostitutes, persons who have multiple sexual partners or whose sexual partners have had sexual relations with others, users of intravenous drugs, and persons who have received unscreened blood products. Health care workers who have direct contact with infected blood are at high risk.

Can HIV infection and AIDS be prevented?

Though AIDS cannot be cured, HIV infection and AIDS can be prevented by avoiding high-risk behavior. The only way to be absolutely certain of avoiding HIV infection through sex is to abstain from sex. But, in general, the best advice to give clients is as follows:

- Keep one faithful sexual partner and remain faithful to her or him. (In polygamous marriages, the husband and his spouses should remain mutually faithful.)
- Use latex condoms. (Unless the couple has had a mutually faithful relationship for many years, or both partners have tested negative for HIV at least six months after their last possible exposure, HIV infection may be present.) Latex condoms are a wise choice for avoiding HIV infection and other STDs. They also prevent pregnancy.
- Avoid sharing needles or using any skin-piercing instrument that has not been disinfected.
- Remember ABC:
 - » A means *abstinence*.
 - » B means *be faithful*.
 - » C means *condoms*.

Special counseling tips:

- Encourage and praise behavior that lessens the risk of infection.
- Assist the client in finding alternatives to high-risk behavior.
- Be nonjudgmental.
- Explain risks and dispel myths in an objective manner.

- **If the client shows any signs of HIV infection or AIDS or is at high risk of contracting HIV infection, refer her or him for testing, if it is available in your area.**

Adapted from: Planned Parenthood Federation of Nigeria. *Interpersonal communication and counseling for family planning: Nigeria three-day curriculum*. Lagos: 1991.

4-3: Contraceptive Methods and Sexuality

Contraceptive method	Possible relationship to sexuality
Pills, injectables, implants (hormonal methods)	<ul style="list-style-type: none"> • To use these methods, the woman does not need to touch her genitals. • Hormonal methods may cause menstrual changes in some women (for instance, bleeding or spotting between periods; longer, shorter, or no periods). These changes may affect frequency of sexual intercourse. (For example, some women may not have sexual intercourse or carry out other activities, such as prayer, while bleeding. Shorter periods may give some women more days when sexual activity is possible.) • Hormonal methods are not linked to lovemaking.
IUD	<ul style="list-style-type: none"> • To check the strings, the woman must touch her genitals. • To insert the IUD, the health care worker must touch the woman's genitals. • The IUD is not appropriate if a woman or her partner has more than one partner (unless latex condoms are also used). • The IUD may cause longer or heavier periods for some women, or spotting or bleeding between periods. These changes may affect frequency of sexual intercourse. (For example, some women may not have sexual intercourse or carry out other activities, such as prayer, while bleeding.) • Some men feel the IUD strings during sexual intercourse. • The IUD is not linked to lovemaking.
Diaphragm with spermicide	<ul style="list-style-type: none"> • To insert and remove the diaphragm, the woman or her partner must touch her genitals. • To fit the diaphragm, the health care worker must touch the woman's genitals. • Spermicides occasionally cause irritation for some women or men. • Inserting the diaphragm may interrupt lovemaking.

Contraceptive Methods and Sexuality (continued)

Contraceptive method	Possible relationship to sexuality
Condoms	<ul style="list-style-type: none"> • To use the condom, the man or his partner must touch the man's penis. • Condoms may reduce sensation. • Condoms may help prolong erection. • Condoms may help avoid premature ejaculation. • The protection latex condoms provide against HIV infection and other STDs may increase pleasure and reduce worry. • Using textured or different colored condoms may add interest. • Putting the condom on may interrupt lovemaking.
Spermicides	<ul style="list-style-type: none"> • To insert spermicide, the woman or her partner must touch her genitals. • Spermicides occasionally cause irritation for some women or men. • Spermicides may improve vaginal lubrication. • Applying spermicide may interrupt lovemaking.
Fertility awareness methods	<ul style="list-style-type: none"> • Couples may worry about correctly identifying the "safe time" for having sex. • The man and woman need self-control during the "unsafe time." • Fertility awareness methods may encourage other forms of sexual expression during the "unsafe time."
Withdrawal	<ul style="list-style-type: none"> • The man needs self-control. • Withdrawal interrupts lovemaking.
Tubal ligation	<ul style="list-style-type: none"> • The doctor must touch the woman's genitals. • Not having to worry about pregnancy may increase sexual enjoyment. • Some women and men associate fertility with sexuality. • Tubal ligation is not linked to lovemaking.
Vasectomy	<ul style="list-style-type: none"> • There are many common misconceptions about the effect of vasectomy on sexuality (loss of virility, impotence, loss of libido, reduced performance). • The doctor must touch the man's genitals • Not having to worry about pregnancy may increase sexual enjoyment. • Some women and men associate fertility with sexuality. • Vasectomy is not linked to lovemaking.

5-1: Paraphrasing

Definition: *Paraphrasing* is restating the client's message simply.

Use: Counselors use paraphrasing to make sure that they have understood what the client has said and to let clients know that they are trying to understand clients' basic messages. Paraphrasing supports the client and encourages her or him to continue speaking.

Example:

Client: "I want to use the IUD, but my sister said that it can travel around your body, and stick in the baby's head."

Counselor: "You have some questions because of what you have heard about the IUD, and you want to find out what is true."

Guidelines for paraphrasing:

- Listen for the client's basic message.
- Restate to the client a simple summary of what you believe is his or her basic message. Do not add any new ideas.
- Observe a cue or ask for a response from the client that confirms or denies the accuracy of the paraphrase.
- Do not restate negative images clients may have made about themselves in a way that confirms this perception. For example, if the client says "I feel stupid asking this," it is not appropriate to say "You feel ignorant."

5-2: Lead Lines: Paraphrasing

The lead lines that follow are quotations from fictitious clients. You can use them as the basis for creating situations for paraphrasing exercises, or create your own.

Charity

My husband doesn't want to use anything because he is gone so much. He doesn't trust me. But how do I know what he is doing when he isn't here?

Elizabeth

I don't want any more children right now. But I was taught that it's wrong to use birth control. Some of my friends do it, though.

James

We can't afford another baby, and my wife has had trouble with the pill and the other methods she has tried. I know I could use something, but if anyone ever found out . . .

Mary

I have friends who use the IUD. But one of them got pregnant. I don't want to get pregnant.

5-3: Clarifying

Definition: *Clarifying* is making an educated guess about the client's message for the client to confirm or deny.

Use: Like paraphrasing, clarifying is a way of making sure the client's message is understood. The counselor uses clarifying to clear up confusion if a client's responses are vague or not understandable.

Example:

Client: "I am using the pill and I like it, but my sister says that with Norplant, I do not need to remember to take anything."

Counselor: "Let me see if I understand you. You are thinking about switching from the pill to Norplant because Norplant would be more convenient for you?"

Guidelines for clarifying:

- Admit that you do not have a clear understanding of what the client is telling you.
- Restate the client's message as you understand it, asking the client if your interpretation is correct. Ask questions beginning with phrases such as "Do you mean that . . . ?" or "Are you saying . . . ?"
- Clients should not be made to feel as if they have been cut off or have failed to communicate. Therefore, do not use clarifying excessively.

5-4: Lead Lines: Clarifying

The lead lines that follow are quotations from fictitious clients. You can use them as the basis for creating situations for clarifying exercises, or create your own.

Helen

My husband's other wife just had a child. I don't know what to do. I'm thinking of having my IUD removed. I don't know if I want another child. Or if we can afford one. But maybe if I have one he'll spend more time here.

Jane

Well, I'm going to start taking the pill this month. But what if my parents find out? What if I can never have children?

Joseph

I'm not going to get a vasectomy. I don't care if we have 20 kids. It's my wife's responsibility. There must be something she can take that won't make her sick.

Sarah

Why do I have to answer all these questions? Just give me something I can use, that no one will find out about.

5-5: Criteria for Useful Feedback

Feedback is a way of helping another person to consider changing her or his behavior. It gives that person information about how she or he affects others. It allows individuals to learn how well their behavior matches their intentions.

- Feedback is *descriptive rather than evaluative*. Describing your observation lets the other person use the feedback or not, as she or he sees fit. Try starting feedback statements with phrases such as “I saw that . . .,” “I observed that . . .,” or “I heard you say . . .”.
- Feedback is *specific rather than general*. To be told that you are “dominating” will not be as useful as to be told, “Just now when we were discussing the issue, you did not listen to what others said, and I felt if I did not accept your arguments, you would attack me.”
- Feedback *takes into account the needs of both the receiver and the giver*. Feedback can be destructive when it serves only our own needs and fails to consider the needs of the person receiving it.
- Feedback is *directed toward behavior that the receiver can do something about*. When people are reminded of shortcomings that they cannot control, they may become frustrated.
- Feedback is *solicited rather than imposed*.
- Feedback is *well-timed*. In general, feedback is most useful at the earliest opportunity after the observed behavior.
- Feedback is *checked to ensure clear communication*. One way of doing this is to have the receiver try to paraphrase the feedback she or he has received to see if it corresponds to what the giver had in mind.
- When feedback is given in a training group, *both giver and receiver have the opportunity to check the accuracy of the feedback with others in the group*. Is this one person’s impression or an impression shared by others?

Adapted from: D. E. Bender and C. Bean. *Counseling skills in family planning: Trainer's handbook*. Chapel Hill, N.C.: Carolina Population Center, University of North Carolina, 1982.

6-1: Counseling Steps: GATHER

- Family planning counseling has six basic steps. You can remember them with the acronym GATHER.
- Counseling should suit the individual client. The telling, helping, and explaining steps will differ from client to client. For instance, a new client who knows little about contraception will need more information than a client who is well informed but comes to the clinic to change methods. A client who is using a method, satisfied with it, and returning only to ask a few questions does not need to be given extensive information about other contraceptive options. Change how you counsel to suit each client's needs.
- Clients may be men or women. For ease of understanding, the client is referred to as "she" in this handout.

G: Greet the Client

- As soon as you meet the client, give her your full attention.
- Be polite; greet the client, introduce yourself, and offer her a seat.
- Assure the client that all information discussed in counseling will be confidential.
- Ask how you can help. Ask the client why she has come to see you. (For information, to obtain a method, to report a problem with a method?)
- If you scheduled the appointment, explain why.

A: Ask the Client about Herself/Assess Her Knowledge and Needs

Listening and questioning are important in this step.

- Help the client talk about her needs, wants, and any concerns or questions she has about family planning. Assess the client's needs. Ask about the client's plans for having or delaying children, and her family situation. If the client is uncertain about the future, start with the present: What is the client's situation now?
- For a new client:
 - » Obtain a basic history. Explain that you are asking for this information to help her choose the best family planning method. Keep questions simple and brief. Look at the client as you speak. Using the clinic's history form, write down the client's:
 - personal data (age, number of pregnancies, number of births, number of living children, sex of children, marital status), previous family planning experience.

- basic medical information. (Many people do not know the names of diseases or medical conditions. Ask the client about any health problems she has had.)
- » Assess what the client knows about contraceptive methods.
- » Help the client assess her risk of contracting or transmitting HIV infection or other sexually transmitted diseases.
- If the client is not new, ask her if anything has changed since the last visit.
 - » If the client's situation has changed, update her medical history, determine if her plans for spacing or limiting births have changed, assess her knowledge of contraceptive methods that may be appropriate to her changed circumstances, and help her reassess her risk of contracting or transmitting HIV infection or other STDs.
- Through the assessment, you should gain a clear idea of why the client has come to the clinic, what needs she wants to meet (for example, to space or limit births, or to get protection against HIV infection or other STDs), and what level of information she already has about family planning.

T: Tell the Client about Family Planning Methods

A client who wants to use family planning needs to know basic information about the available methods before she settles on a particular method. What she needs to know depends on which methods interest her and on what she already knows. If the client has attended group education sessions, or has acquired knowledge from other sources, she may need less information.

- Tell the client which methods are available that will meet her needs as identified during the assessment.
- If the client has not already expressed an interest in a particular method, ask her which methods interest her.
- Fill in gaps in the client's knowledge about the following:
 - » the characteristics, risks, effectiveness, and side effects of the methods that she is interested in, including protection against HIV infection and other STDs
 - » the human reproductive system, as it relates to how those methods work
- Encourage the client to ask questions, and provide feedback to be sure she understands. Gently correct any misunderstandings she has about these methods.

H: Help the Client Choose a Method

Help the client match family plans, needs, and preferences with a family planning method. Listening and questioning are important in this step.

- Ask the client if there is a method she would like to use. Some clients will know what they want. Others will need help thinking about the choices.
- Ask the client if she needs to consider what her partner wants. If so, what method would the couple like to use?
- If the client has assessed herself as having some risk of contracting or transmitting STDs, including HIV infection, help her consider whether the contraceptive she is interested in offers protection against these diseases.
- Ask the client if there is anything she does not understand. Repeat information when necessary.
- Some methods are not safe for some clients. When a method is contraindicated for a particular client based on her medical history, tell the client. Explain why clearly. Then help the client choose another method. If necessary, refer the client to another health care provider for medical evaluation.
- Check whether the client has made a decision. Specifically ask, "What method have you decided to use?"

If the client decides not to use contraception:

- Be sure the client understands the risk of pregnancy if contraception is not used. She should also understand the health risks associated with pregnancy.
- As appropriate, review with the client the risk factors for contracting or transmitting STDs, including HIV infection.
- Advise the client about other services, such as prenatal and maternity care.
- Tell the client to return if she has a change of mind.

E: Explain How to Use a Method

If the client chooses a temporary method, help her know how to use it, understand side effects and warning signs, obtain the method, and plan follow-up care.

Knowing how to use a method:

- Explain how to use the method.
- Ask the client to repeat the instructions. Listen carefully to make sure she understands.

- If possible, give the client printed material about the method to take home.

Understanding side effects and warning signs:

- Describe possible side effects. Explain how long these may last. Clearly tell the client what to do if they occur. Differentiate normal side effects, which are inconvenient, from warning signs, which indicate problems. Tell the client what to do or where to go if she experiences warning signs of serious problems.
- Ask the client to repeat the information about warning signs of serious problems.

Obtaining the method:

- Tell the client about any fees she is expected to pay.
- Provide the method, or tell the client how, when, and where it will be provided.

Planning follow-up care:

- Explain how to get supplies (for methods requiring ongoing supplies).
- Schedule a follow-up visit, if necessary.

If the client expresses an interest in tubal ligation or vasectomy:

- Follow the steps for counseling for permanent methods. These are explained in Module 12.

R: Return for Follow-Up

At the follow-up visit:

- Ask the client if she is still using the method.
- If the answer is yes, ask the client if she has any problems with the method.

If the client is not having problems with the method:

- Ask how the client is using the method, and provide guidance to ensure that it is being used correctly.
- Ask if the client has any questions. If she does, respond to them.

If the client is having a problem with the method:

- Determine what the problem is.
- If the client is experiencing side effects, find out what they are. For common side effects, reassure her that they are not dangerous. Do not dismiss her concerns; they are important to her, whether or not they are medically important. Suggest what she can do to relieve them. If she continues to be unhappy, suggest trying

another method. If she has warning signs of serious problems, refer for medical evaluation.

- Ask how the client is using the method, and provide guidance to ensure that it is being used correctly.
- Ask if the client has any questions. If she does, respond to them.

If the client, for any reason, wants to try another method:

- Ask the client if she has another method in mind. If she does, review what the client knows about the method, to be sure she is well informed.
- If the client does not have a method in mind, tell her about other methods again. Help her choose one, keeping in mind her reasons for wanting to switch methods.
- Remember—changing methods is normal and acceptable. A person's situation can change, leading her to choose a different method.

If the client, for any reason, wants to discontinue a method:

- Help the client do so. If necessary, refer her elsewhere. Remind the client that prenatal care is important and tell her where to go for prenatal care if pregnancy should occur.
- As appropriate, review with the client the risk factors for contracting or transmitting STDs, including HIV infection, and the ways to protect against these diseases.

Adapted from: C. Lettenmaier and M. Gallen. Why counseling counts! *Population Reports* series J, no. 36. Baltimore: Population Information Program, Johns Hopkins University, 1987.

Association for Voluntary Surgical Contraception. *Family planning counseling and voluntary sterilization: A reference guide for counselors*. New York: 1989.

7-1: Family Planning Questions

USES OF QUESTIONS

Questions can be used to:

- assess the needs of the client
- find out what the client already knows about family planning
- learn how the client feels
- help the client anticipate how she or he might feel if she or he takes a certain action
- help the client reach a decision
- help the client act on a decision

TYPES OF QUESTIONS

Closed questions have a limited number of responses (*yes*, *no*, a number, or a few words). Counselors can use closed questions to start sessions, gathering data that can indicate areas that need further exploration in decision making. They can be used to get information, such as a medical history. The following are examples of closed questions:

- How old are you?
- Which family planning methods have you used?
- How many children do you have?
- How many children do you want to have?
- When did you decide that you did not want any more children?

Open questions have many possible answers, and encourage the client to talk about her or his own thoughts, feelings, knowledge, and beliefs. These questions often begin with “how” or “what.” The following are examples of open questions:

- What do you know about condoms?
- How do you feel about not having any sons?
- How did you decide that you are ready for tubal ligation?
- What does your partner think about your using contraception?

Note: “Why” questions may be intimidating or seem judgmental. It is preferable to use “what,” as in “What are your reasons for . . . ” or “What makes you think . . . ”.

Probing questions help the counselor clarify the client’s responses to open questions. The following are examples of probing questions:

- What makes you think that an IUD will make you infertile?
- What if you have a tubal ligation, then meet a man you want to marry?
- Do you expect your partner to support your use of the rhythm method? Do you anticipate any problems?

Some questions steer a client to answer in a particular way. This type of question should never be used. The following are examples:

- Don't you think that the pill would be a better choice?
- Would you rather have another child or a vasectomy?
- Are you happy or unhappy about being pregnant?

7-2: Assessing Personal Risk of STD Infection: Questions for Clients

- Have I had more than one sexual partner?
- Have I had a sexual partner who has had more than one partner?
- Have I had a sexually transmitted disease?
- Have I had sex (vaginal, oral, or anal) with someone who has a sexually transmitted disease?
- Have I ever had sex (vaginal, oral, or anal) with someone who may be infected with the virus that causes AIDS (HIV)?
- Have I gotten injections from dirty needles?

8-1: Basic Facts about the Female Reproductive System

QUESTION: What is the vagina?

POSSIBLE RESPONSE: The vagina is a passage that connects the womb (uterus) with the outside of the body. Intercourse takes place in the vagina. Menstrual blood and babies pass through the vagina.

QUESTION: What is the cervix?

POSSIBLE RESPONSE: The cervix is the narrow neck of the womb, that connects the uterus with the vagina. When a man climaxes (has an orgasm), sperm travels through the cervix to reach the womb. Menstrual blood and babies leave the womb through the cervix. The cervix has to widen to let a baby through, and this is what happens when a pregnant woman goes into labor.

QUESTION: What is the clitoris?*

POSSIBLE RESPONSE: The clitoris is a small bud of tissue, covered with a soft fold of skin and located above the urinary opening. It is very sensitive to touch. During sexual arousal, the clitoris swells and becomes erect. It plays an important role in the woman's sexual pleasure and climax (orgasm).

QUESTION: What is the main function of the womb?

POSSIBLE RESPONSE: The womb houses and protects the growing baby.

QUESTION: What do the ovaries do?

POSSIBLE RESPONSE: Ovaries produce eggs and female hormones. Female hormones give women their female characteristics, like breasts, the way their voices sound, and their interest in sex.

QUESTION: How often does an egg leave one of the ovaries?

POSSIBLE RESPONSE: An egg leaves one of the ovaries each month.

QUESTION: What do the (fallopian) tubes do?

POSSIBLE RESPONSE: A tube connects each ovary with the womb. When the egg leaves the ovary, it travels through the tube to the womb. Besides connecting these two organs, the tubes provide a favorable place for fertilization.

*In some cultures, the clitoris and other parts of the female genitalia may be removed or altered in initiation rites. If this practice is common in areas where participants will do counseling, they will need to be prepared to talk sensitively about the special sexual, reproductive health, and family planning concerns of clients who have undergone genital mutilation. This curriculum does not address these issues.

QUESTION: What is fertilization?

POSSIBLE RESPONSE: Fertilization is when the man's seeds (sperm) enter the egg.

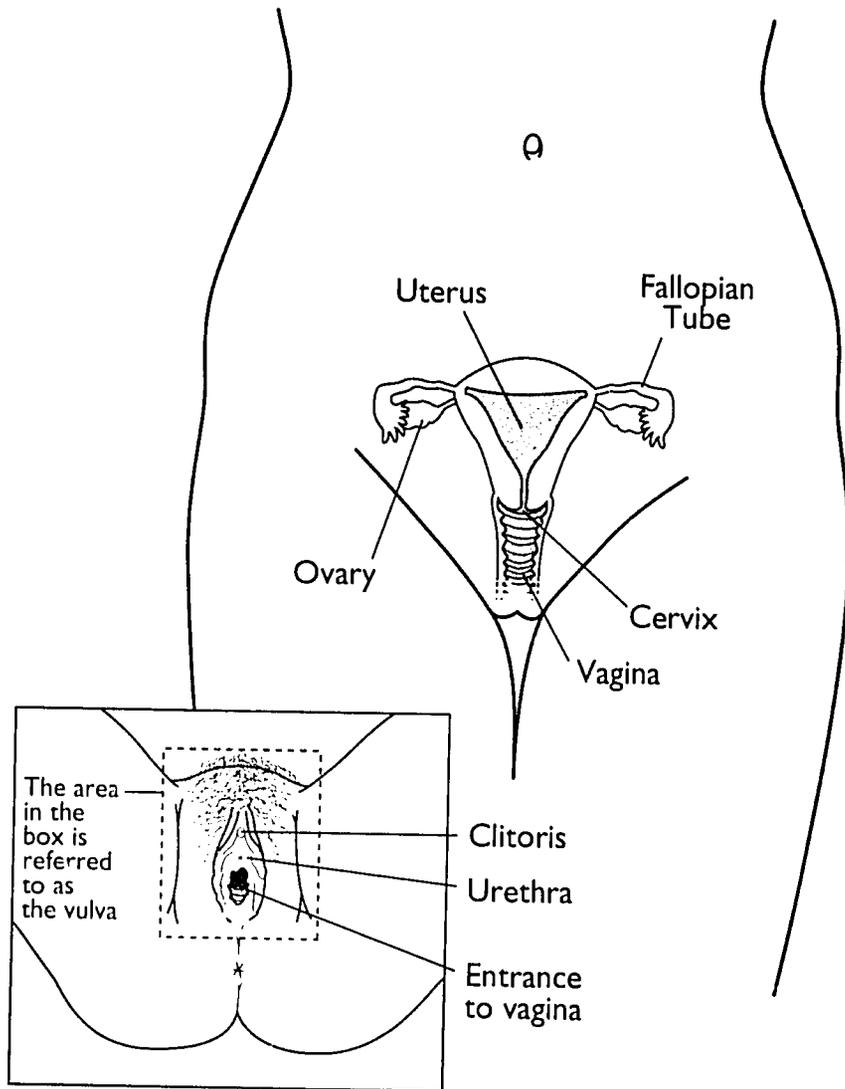
QUESTION: What happens to the fertilized egg?

POSSIBLE RESPONSE: The fertilized egg takes another four or five days to travel down the tube to the womb. The egg attaches to the womb. The woman is now pregnant.

QUESTION: What happens if the man's seeds do not reach the egg?

POSSIBLE RESPONSE: The egg passes out of the womb as part of the woman's menstrual blood.

8-2: The Female Reproductive System



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Illustration by David Rosenzweig

8-3: Basic Facts about the Male Reproductive System

QUESTION: What are the two functions of the testicles?

POSSIBLE RESPONSE: The testicles produce sperm and male hormones. Male hormones give men their masculine characteristics, such as beards, muscles, and sex drive.

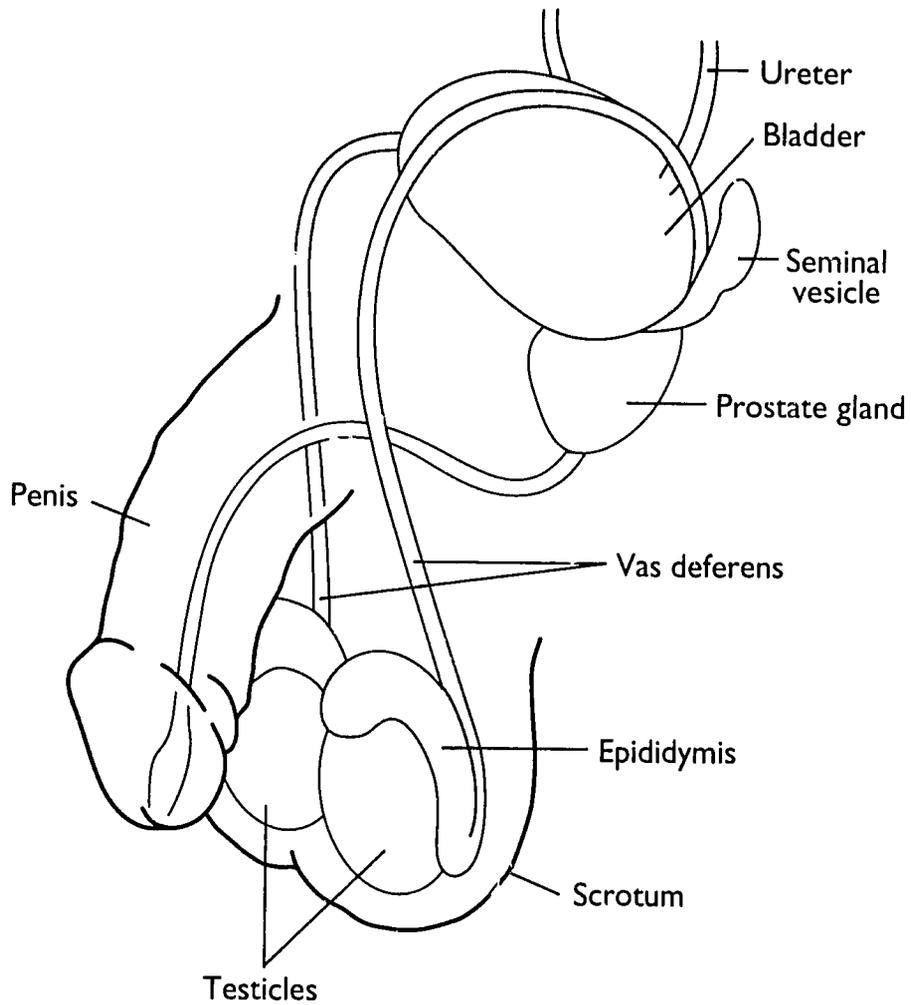
QUESTION: What happens during a man's sexual climax?

POSSIBLE RESPONSE: The seeds (sperm) travel through two tubes (vasa deferentia), mix with semen, and come out of his penis. During the climax, muscles tighten, causing a feeling of pleasure called orgasm.

QUESTION: What is semen?

POSSIBLE RESPONSE: The liquid that comes out of the penis when a man climaxes. It contains sperm and other fluid. Sperm make up only a tiny amount of the semen. After a man has had a vasectomy, the semen no longer contains sperm.

8-4: The Male Reproductive System



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Illustration by David Rosenzweig

8-5: Effective Use of Informational Materials

- Clients must have a clear view of materials.
- Clients must have time to look at and understand illustrated material.
- Counselors should point to a picture of an organ or reproductive part whenever they talk about one.
- If a picture shows a side view or does not show the location of the organs in the human body, counselors should explain the orientation or point out where the area is on their own bodies. This is particularly true for female reproductive anatomy, which is mostly internal and cannot be seen.

TYPES OF INFORMATIONAL MATERIALS:

- **Brochures:** good for clients to take home; not very effective in large groups; can be shared with other people, such as the client's partner or neighbors
- **Posters:** provide basic information, but not many details; may raise awareness and generate interest
- **Contraceptive methods:** good for demonstrating use of some methods (for example, the condom); allowing clients to handle them can help clients feel more comfortable with them (for example, demonstrating that the tip of an IUD is blunt)
- **Illustrated flipcharts:** useful for small groups as well as individuals; words on the back of a flipchart can help the health care worker guide the discussion; can provide illustrations of contraceptive methods, male and female anatomy, conception, pregnancy, and birth
- **Videos/films:** can make effective use of clients' waiting time; should be followed by discussion

8-6: Temporary Contraceptives: How to Correct Common Misconceptions

Correcting common misconceptions is an important part of family planning counseling. When responding to clients' misconceptions, give clients information that is accurate, without making them feel ignorant. It can be helpful to explain why the client's information is not true. Below are examples of common misconceptions, and suggestions for correcting them.

THE PILL

COMMON MISCONCEPTION: The pill is a strong, dangerous drug. Using it can cause permanent damage to a woman.

POSSIBLE RESPONSE: The pill has been tested more than any other drug. It is a safe, effective contraceptive method that has been used by millions of women. Very few women have had any serious problems. The pill is safer than pregnancy and childbirth for most women.

COMMON MISCONCEPTION: The pill makes it impossible for a woman to ever have a baby.

POSSIBLE RESPONSE: This is not true. After stopping the pill, it may take a few months for the woman to get pregnant. But this delay is usually not more than three months.

COMMON MISCONCEPTION: The pill causes cancer.

POSSIBLE RESPONSE: Many studies have been done on the pill and cancer. None have shown that the pill causes cancer. In fact, the pill provides protection against two types of cancer: cancer of the ovary and cancer of the lining of the womb.

COMMON MISCONCEPTION: The pill causes birth defects.

POSSIBLE RESPONSE: Many studies have been done on this topic. There is no evidence that a child conceived during or after a mother's use of the pill is more likely to have birth defects than the average baby.

COMMON MISCONCEPTION: The pill builds up in the woman's body.

POSSIBLE RESPONSE: Pills dissolve in a woman's stomach, just like other medicines. They do not build up in the woman's body.

DEPO-PROVERA (DMPA)

COMMON MISCONCEPTION: Depo-Provera causes cancer.

POSSIBLE RESPONSE: A 1986 World Health Organization study found no increase in cancer among women using Depo-Provera. That study also found that Depo-Provera provides some protection against cancer of the ovary and cancer of the lining of the womb.

COMMON MISCONCEPTION: Developed countries unload contraceptives like Depo-Provera, which are not approved for their own women, on developing countries.

POSSIBLE RESPONSE: Depo-Provera has been approved by Sweden, the United Kingdom, France, West Germany, and the United States for use nationally, as well as for export and foreign assistance. It has also been approved by the World Health Organization and the International Planned Parenthood Federation.

THE IUD

COMMON MISCONCEPTION: A woman who uses the IUD will never be able to have a baby, even after she has the IUD removed.

POSSIBLE RESPONSE: Almost all women who use the IUD are able to have babies after they have the IUD removed.

COMMON MISCONCEPTION: The IUD causes cancer.

POSSIBLE RESPONSE: Extensive studies have shown that the IUD does not increase the risk of cancer.

COMMON MISCONCEPTION: The IUD can travel through a woman's body.

POSSIBLE RESPONSE: The IUD almost always stays in the womb until a health care worker removes it. If it does come out by itself, which is uncommon, it usually comes out through the vagina. The woman can check the strings of the IUD to reassure herself that the IUD is still in place.

COMMON MISCONCEPTION: If a woman becomes pregnant while using an IUD, it will become embedded in the baby's body.

POSSIBLE RESPONSE: Very few women become pregnant while using an IUD. In the rare cases when they do, the IUD cannot become embedded in the baby or cause a deformity. However, women who do become pregnant using an IUD face an increased risk of miscarriage. The risk of miscarriage is decreased if the IUD is removed early in pregnancy.

CONDOMS

COMMON MISCONCEPTION: If the condom comes off, it can travel through the woman's body.

POSSIBLE RESPONSE: Except during labor, the opening between the vagina and the womb is tiny. A condom cannot pass through it. If a condom comes off during sex, the woman can remove it from the vagina.

COMMON MISCONCEPTION: Use of condoms will weaken a man, causing impotence.

POSSIBLE RESPONSE: There is no medical reason why condom use would cause impotence.

COMMON MISCONCEPTION: Men only use condoms with prostitutes.

POSSIBLE RESPONSE: Condoms are used by married couples all over the world. In Japan, for example, condoms are the most widely used contraceptive among married couples.

COMMON MISCONCEPTION: Condoms often break during sex.

POSSIBLE RESPONSE: You can demonstrate a condom's strength by blowing one up like a balloon. New, properly stored condoms are very strong. Only old or used condoms, or condoms that have been stored in a hot place, are likely to deteriorate to the point that they will break. Properly used, a new condom is unlikely to break.

SPERMICIDES

COMMON MISCONCEPTION: Spermicides lead to deformed babies.

POSSIBLE RESPONSE: There is no medical evidence for this myth.

COMMON MISCONCEPTION: Spermicides, contraceptive sponges, and diaphragms cause cervical cancer.

POSSIBLE RESPONSE: These methods may help prevent cervical cancer: they protect the cervix against sexually transmitted diseases, which can increase the risk of cancer.

Handouts 12-2 and 12-3 provide information on common misconceptions about tubal ligation and vasectomy.

Adapted from: C. Lettenmaier and M. Gallen. Why counseling counts! *Population Reports* series J, no. 36. Baltimore: Population Information Program, Johns Hopkins University, 1987.

Population Reference Bureau, IMPACT Project. *Contraceptive safety: Rumors and realities*. Washington, D.C.: 1988.

8-7: Questions Clients Ask about HIV Infection

QUESTION: “My partner is HIV-positive. Will I get AIDS?”

POSSIBLE RESPONSE: “We don’t know for sure, but the risk is very serious for you.” The client needs to understand that HIV can be transmitted through vaginal, oral, and anal intercourse.

QUESTION: “I got a blood transfusion a year ago. Could I have gotten HIV?”

POSSIBLE RESPONSE: The answer to this question depends upon whether the blood supply was screened for HIV at the time the transfusion was obtained. If it was, the counselor might respond, “Probably not, because blood used for transfusions is tested to be sure it does not contain HIV.”

If blood was not routinely screened during this period or at this site, the counselor might say, “We don’t know for sure,” and explain why.

QUESTION: “A few years ago, I had sex with someone who now has AIDS. Will I get AIDS?”

POSSIBLE RESPONSE: “We don’t know for sure. What’s important is for you to protect yourself and your partner now.”

- In these three cases, in addition to answering the client’s immediate question, the counselor should:
 - » Let the client know if testing for HIV infection is available and, if so, where.
 - » If testing is unavailable, help the client to deal with the uncertainty of not knowing and to consider seriously the need for protection.
 - » Ensure that the client understands that, if infected, she or he needs to avoid transmitting the virus to others.
 - » Review the use of condoms, as explained in the book *Talking with Clients about Family Planning*.
 - » Review the contraceptive effectiveness of condoms. Some clients choose to use an additional family planning method to gain more effective protection against pregnancy.

9-1: Client Profiles for Role Plays: Helping Clients Choose a Temporary Family Planning Method

Role 1:

I am 19 years old and go to college. I like my boyfriend, but I don't know if we'll stay together. I want to get pregnant someday, but not now. I don't want anyone to know I'm using contraceptives.

Role 2:

I am 35 years old and work in an office. I have two children. My husband would like to have more children. I want to wait until my baby is four. I don't want my husband to know that I'm using contraceptives.

Role 3:

I am 25 years old and have three children. I want to use contraception but don't know which method to use. I want the counselor to tell me what to use.

Role 4:

I am 21 years old and have two children. My husband works in the city now and is away from home a lot, so I don't want to keep taking the pill every day. Besides, it might make him suspicious.

12-1: Facts about Reversal

- Permanent contraception ends an individual's ability to have children.
- Tubal ligation and vasectomy should be regarded as permanent, because reversal procedures:
 - » may be unavailable.
 - » are costly.
 - » often fail.
 - » require that the doctor have special skills.
 - » usually take about four hours to perform.
 - » may not be appropriate for some individuals because of medical reasons.
- For clients who are suitable candidates for reversal, success cannot be assured.
- The success of reversal depends on a variety of factors, including:
 - » the age, health, and other fertility factors of the client and the partner
 - » the site of occlusion
 - » the length of undamaged tubes or vasa that remains
 - » the reconstructive technique used
 - » the skill and experience of the surgeon performing the reversal procedure
- Individuals may be inappropriate candidates for reversal, because of:
 - » age
 - » poor health
 - » fertility impairments
 - » partner's infertility
 - » insufficient length of tubes or vasa for reversal

12-2: Tubal Ligation: How to Correct Common Misconceptions

When responding to common misconceptions about tubal ligation, give clients information that is accurate, without making them feel ignorant. It can be helpful to explain why clients' information is not true. Below are examples of common misconceptions about tubal ligation, and suggestions for correcting them.

COMMON MISCONCEPTION: Tubal ligation is a painful, difficult procedure.

POSSIBLE RESPONSE: Tubal ligation is a simple procedure often performed under local anesthesia. It can be done as an outpatient procedure (the client leaves the same day) or after the birth of a baby. Women may have some pain after the procedure, but this discomfort usually is minor and lasts only a few days.

COMMON MISCONCEPTION: Tubal ligation makes a woman weak.

POSSIBLE RESPONSE: Women who have had tubal ligation are as strong as other women. They are no more likely to have physical or mental problems than other women.

COMMON MISCONCEPTION: After tubal ligation, a woman will not have menstrual periods.

POSSIBLE RESPONSE: After tubal ligation, women continue to have their menstrual periods just as they did before surgery. They stop having periods after menopause.

COMMON MISCONCEPTION: Tubal ligation makes a woman frigid.

POSSIBLE RESPONSE: Blocking the tubes does not change sexual desire or performance. In fact, some women find that they enjoy sex more after tubal ligation because they do not need to worry about getting pregnant.

COMMON MISCONCEPTION: Tubal ligation can be undone (or untied) after seven years.

POSSIBLE RESPONSE: Tubal ligation is intended to be permanent. Except in the rare cases in which the procedure is unsuccessful, the tubes remain closed permanently. Although tubal ligation can, in some cases, be reversed, the reversal operation is not always available; it is expensive and not always successful.

Handouts 8-6 and 12-3 provide information on common misconceptions about temporary methods and vasectomy.

12-3: Vasectomy: How to Correct Common Misconceptions

When responding to common misconceptions about vasectomy, give clients information that is accurate, without making them feel ignorant. It can be helpful to explain why clients' information is not true. Below are examples of common misconceptions about vasectomy, and suggestions for correcting them.

COMMON MISCONCEPTION: Vasectomy is the same as castration.

POSSIBLE RESPONSE: Vasectomy is not castration. Castration is the removal of the testicles. This is not done in vasectomy. Only one or two tiny incisions (or punctures, in the case of no-scalpel vasectomy) are made and two tiny tubes are cut or tied off.

COMMON MISCONCEPTION: A man who has had vasectomy cannot perform sexually or enjoy sex as before.

POSSIBLE RESPONSE: The operation does not affect a man's sexual desire or performance. A man's penis is the same as before. He can still have erections. His feeling at ejaculation will be the same as before vasectomy. The only difference is that his semen will no longer have sperm. Sperm are only a small part of the fluid men ejaculate, so the man will not notice a difference. A man who has had vasectomy still has his sexual desire, strength, and pleasure.

COMMON MISCONCEPTION: Vasectomy can cause heart problems and weaken the immune system.

POSSIBLE RESPONSE: Men who have had vasectomy do not have an increased risk of either cardiovascular disease or immune system problems. The long-term effects of vasectomy on health have been studied extensively. No ill effects have been shown.

COMMON MISCONCEPTION: Vasectomy causes weight gain.

POSSIBLE RESPONSE: Vasectomy does not cause weight gain. Vasectomy does not cause any of the other changes commonly associated with castration, such as loss of masculine characteristics (for example, changes in beard and voice).

Handouts 8-6 and 12-2 provide information on common misconceptions about temporary methods and tubal ligation.

12-4: Family Planning Counseling and Voluntary Sterilization: A Reference Guide for Counselors

The **purpose** of family planning counseling is to ensure that clients make free and informed decisions about reproduction and contraception. The client makes the decision after receiving unbiased, complete information about the available choices and after considering how those choices relate to his or her own needs and circumstances. The **responsibilities** of the counselor are as follows:

- To assess the client's knowledge of family planning alternatives and to provide any missing information
- To help the client arrive at an understanding of his or her needs and circumstances, as they relate to childbearing and family planning
- To help the client come to an independent decision about which choice is right for him or her

While carrying out these responsibilities, the counselor treats the client respectfully and encourages the man or woman to talk about worries, fears, interests, and needs. The counselor spends as much time listening to clients as talking to them. The counselor remains neutral about the client's choice. A decision to have another child, after having considered all the possible choices, is as valid an outcome of counseling as a decision for some form of contraception.

This handout highlights some of the basic points of effective counseling. Because of the surgical and permanent nature of voluntary sterilization, these guidelines devote more attention to that method than to temporary methods. Nevertheless, the counselor is responsible for being fully knowledgeable about both temporary and permanent methods.

Preparation for counseling: Ask yourself—

- Emotional climate
 - » Can I give the client my full attention without being interrupted?
 - » Can I provide a comfortable atmosphere for the client?
- Setting
 - » Does the setting encourage discussion and provide privacy?
 - » Is the counseling area tidy and free of distraction?
 - » Are there comfortable chairs for the client or couple and for me?

- **Materials**
 - » Do I have the necessary forms (client record, informed consent)?
 - » Do I have visual aids (flip charts, brochures, samples of methods)?
 - » Do I have materials that remind me of the characteristics, benefits, and risks of the various methods?

The counseling session begins

- **Getting started**
 - » Begin by putting the client at ease. Introduce yourself.
 - » Ask the client why she or he has come to see you: information? method? problem with a method?
 - » If you scheduled the appointment, explain why.
 - » Explain the purpose of the counseling session.
- **Gathering information from the client**
 - » Personal data (age, number and sex of children, marital status)
 - » Previous contraceptive experience
 - » Health status
- **Assessing what the client knows about the following:**
 - » Human reproductive system
 - » Benefits, risks, side effects of temporary and permanent methods
- **Providing information to the client**
 - » Tailor information depending upon the client's knowledge and family planning goals.
 - » Provide accurate, unbiased information.
 - » Correct misunderstandings.
 - » Fill in gaps in the client's knowledge:
 - Human reproductive system
 - Benefits, risks, side effects of temporary and permanent methods
 - Benefits, risks of not using contraception

- » Encourage the client to ask questions and to provide feedback, to be sure she or he understands.
- » If appropriate, explain what the client can do to prevent the transmission of sexually transmitted diseases, including AIDS.

If the client decides not to use contraception:

- Be sure the client understands the risk of pregnancy occurring if contraception is not used. The client should also understand the health risks associated with pregnancy in his or her particular case.
- Tell the client to return if she or he has a change of mind.
- Advise the client about other services, such as prenatal and maternity care.

If the client decides to use a temporary method:

- Screen for appropriateness (contraindications, ability to use effectively, etc.).
- Explain and demonstrate the method in detail: how to use, risks, benefits, danger signals, what to do if a problem arises, whom to contact if the client wants to discontinue.
- Prepare the client for the inconveniences and common side effects of the method.
- Explain how to get supplies.
- Tell the client about any fees she or he is expected to pay.
- Provide the method or refer.
- Schedule a follow-up visit, if appropriate.

If the client expresses an interest in voluntary sterilization:

- Screen for eligibility.
- Be sure the client understands that the method involves surgery and is intended to be permanent.
- Assess the client's decision and feelings. Psychologically prepare the client for ending fertility. Use probing questions such as:
 - » When did the client decide to have no more children?
 - » Why does the client want to end fertility? (completed family size, economic reasons, health reasons, etc.)
 - » How did the client first learn about sterilization? (self, partner, nurse, doctor, friend, field worker, etc.)

- » How long has the client been considering sterilization?
- » What does the partner think?
- » Does the client know anyone who has been sterilized?
- » How would the client feel if circumstances changed after the sterilization?
(divorce, remarriage, death of child or partner)
- Ask yourself: “Is the client making a well-considered decision?”

Some signs of a sound decision:

- » Mature individual
- » Desired family size achieved or exceeded
- » Support for decision from partner or relative
- » Marital stability
- » Realistic expectations
- » Free from stress
- » Confident in decision
- » Well-established desire to end fertility
- » Well informed

Some warning signs:

- » Young age
- » Few children
- » Pressure from someone else
- » Marital instability
- » Unrealistic expectations
- » Partner not in agreement
- » Temporary stress
- » Unresolved conflict or doubt
- » Economic inducement
- » Excessive interest in reversal

If you believe the client is at risk of dissatisfaction or regret after sterilization:

- Explain that the client has characteristics that make dissatisfaction or regret likely. Discuss them with the client. For instance: “We’ve learned that men or women in your situation who have had a sterilization sometimes change their minds about the choice after the operation is done. This is because . . .”
- Ask the client to spend more time considering the decision. Encourage him or her to use temporary methods in the meantime.

Possible outcomes:

- The client agrees to reconsider and may or may not use temporary contraception in the meantime. Schedule another appointment.
- The client may change his or her mind and decide to use a temporary method or no method.
- The client may persist in the request. If so, consult your supervisor. Consider referring the client to a more knowledgeable or experienced counselor.

If you believe the client’s decision for sterilization is informed, voluntary, and well considered:

- Explain in detail the benefits, risks, and side effects.
- Psychologically prepare the client for surgery: what to expect in the operating theater, postoperative effects.
- Provide oral and written preoperative instructions (if you are responsible for this task in your clinic).
- Tell the client about any fees she/he is expected to pay.
- Advise the client to use temporary contraception before surgery (and afterwards, for vasectomy).
- Complete informed consent procedures. Be sure the client understands the six points of informed consent and what he or she is signing. Encourage the client to ask questions. Obtain the client’s signature or mark. If the client is illiterate, obtain a witness’s signature attesting that the client has signed the informed consent form. Six points of informed consent:
 - » Availability of temporary methods
 - » Surgical procedure
 - » Benefits and risks of sterilization, including small risk of failure
 - » Intended to be permanent

- » If successful, no more pregnancies
- » Option to decide against the procedure at any time before the operation
- Schedule an appointment for medical screening and surgery.

Remember: The goal of counseling is a client who makes an informed, voluntary, well-considered decision.

12-5: Regret after Tubal Ligation and Vasectomy

- Regret is often triggered by a major change in circumstance, such as the loss of a child or partner, or remarriage.
- Regret is sometimes strong enough to lead clients to seek reversal. Because reversal is usually not a realistic option, it is important to help clients avoid regret.
- Clients who show warning signs of future regret require careful counseling.
- Clients who show warning signs of regret should not necessarily be denied permanent contraception.
- Rather, these characteristics should signal the counselor to devote special time and care to ensuring the client carefully weighs the choice of permanent contraception and its alternatives.

12-6: Informed Consent for Permanent Contraception

- Informed consent is the client's voluntary decision to undergo a procedure, with full understanding of the relevant facts. Consent is voluntary when it is given of the client's own free will and not by means of special inducement (such as cash payment), force, fraud, bias, or other forms of coercion.
- In order to make an informed choice regarding permanent contraception, the client must be told and must understand the six elements of informed consent.
 1. **Temporary methods of contraception are available to the client or the client's partner.** The client has a choice between temporary and permanent methods.
 2. **Tubal ligation/Vasectomy is a surgical procedure.** The client will undergo an operation.
 3. **There are risks and benefits associated with the procedure** (see the sections on explaining tubal ligation and vasectomy in the book *Talking with Clients about Family Planning*).
 4. **The client will no longer be able to have children.** Fertility will be ended.
 5. **The effect of this procedure is meant to be permanent.**
 6. **The client has the option to decide against the procedure without sacrificing the right to other services.** The client may change his or her mind at any time before the operation.

I 2-7: Sample Informed Consent Form

I, (client's name), the undersigned, request that a sterilization via (specify the procedure) be performed on my person. I make this request of my own free will, without having been forced or given any special inducement. I understand the following:

1. There are temporary methods of contraception available to me and my partner.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. This surgical procedure involves risks, in addition to benefits, both of which have been explained to me.
4. If the procedure is successful, I will be unable to have any more children.
5. The effect of the procedure is permanent.
6. I can decide against the procedure at any time before the operation is performed (and no medical, health, or other benefits or services will be withheld from me as a result).*

Signature or mark of client

Date

Signature of attending doctor or
delegated assistant

Date

If the client cannot read, a witness of the client's choosing, preferably of the same sex and speaking the same language, must sign the following declaration:

I, the undersigned, attest to the fact that the client has affixed his/her thumbprint or mark in my presence.

Signature or mark of witness

Date

*The clause in parentheses must be included when tubal ligation or vasectomy services, are provided concurrently with such other services, such as obstetrical, antenatal, or neonatal care.

13-1: Pregnant and Postpartum Women

- **Counseling needs:**

- » A pregnant woman is likely to be most concerned about her own health and that of the baby.
- » The new mother is likely to be most concerned about her own recovery and the health and well-being of the baby; she also needs rest.
- » Breastfeeding is a concern of pregnant and postpartum women. Clients often worry about the effects of contraception on breast milk.
- » Pregnant and postpartum women may or may not be interested in discussing contraception, and their wishes should be respected.
- » Some pregnant and postpartum women have multiple contacts with the health care system (for example, prenatal and well-baby visits) when they can learn about family planning. Other women may come to a facility just for the birth or may deliver their babies at home; they may have few opportunities to talk about family planning with a health care provider.
- » Pregnant and postpartum women often experience psychological changes, physical discomfort, and other stress.
- » Pregnant and postpartum women may be concerned about their sexuality and about meeting their partner's sexual needs. They may not know whether it is safe to have sexual intercourse during pregnancy. While they are pregnant, they may wonder if their spouses or partners are having sexual intercourse with someone else. Pregnant or postpartum women may worry that their partners will want to have sexual intercourse as soon as they return home after the delivery. Many women follow cultural or medical norms about postpartum sexual abstinence, but some do not. Pregnant and postpartum women may be reluctant to discuss sexual concerns with providers.

- **Suggestions for counseling pregnant and postpartum women:**

- » Pregnant women and women who have just delivered need clear and accurate information about breastfeeding, both for infant nutrition and for contraceptive purposes.
- » Breastfeeding (the lactational amenorrhea method, or LAM) can be an effective contraceptive if certain conditions are met: The woman breastfeeds the baby on demand, she has not yet menstruated, the baby is receiving no other food or liquid besides breast milk, the baby is younger than six months old, there are no more than six hours between any two breastfeedings. If a woman does not want

to use LAM, she can use other contraceptive methods while breastfeeding (see *Talking with Clients about Family Planning*).

- » Family planning counseling should be offered during the prenatal period. This allows the woman time to consider and discuss her options well before delivery and to make any arrangements needed.
- » The period of labor and delivery is one of the few times that many women receive health care. Yet because of the pain and stress involved, it is not the best time for family planning counseling. Laboring women are preoccupied with their own pain and the birth outcome.
- » Unless the pregnant woman has expressed an interest in getting an IUD or tubal ligation immediately after delivery, there is no reason to counsel during labor. Even for a woman interested in the IUD or tubal ligation immediately postpartum, providing counseling in early labor depends upon the receptivity of the woman and her ability to discuss contraceptive options.
- » In the maternity setting, it is best if the person responsible for counseling is not part of the labor and delivery team, since these staff members have other responsibilities and an unpredictable workload.
- » Providers may offer family planning counseling after delivery, while the woman is recovering and before she goes home with the new baby.
- » In busy and crowded maternity wards, the counselor will need to make special efforts to provide privacy and confidentiality for the woman.
- » If the woman is not interested in talking about contraception, the counselor can give her referral information so that she can seek out contraceptive services at a later time or return if she is interested.
- » For women who do not want to discuss family planning, condoms and spermicides can be placed at various locations in the health facility so women can pick them up without having to ask for them.

13-2: Men

- **Counseling needs:**

- » Men may need to be encouraged both to support women's use of contraception or to use contraception themselves. This may be especially true if male contraceptive use is uncommon in the community.
- » Men usually have less information than women about reproduction and family planning, and have fewer opportunities to talk to health care workers about their health.
- » Men tend to be more concerned about sexual desire and performance than women.
- » Compared to women, men may find it more difficult to talk about sexual problems or worries.
- » Some men find it easier to discuss sexuality and family planning with male counselors. Other men feel comfortable talking with a female counselor, provided she is knowledgeable, is unembarrassed, and treats them with respect.
- » The contraceptive method that offers the most protection against HIV infection and other sexually transmitted diseases is a male method—the condom.
- » Men may not be comfortable coming to a family planning clinic, particularly if it primarily serves women.

- **Suggestions for counseling men:**

- » Because men often have little knowledge of reproduction, contraception, and anatomy (particularly female anatomy), the counselor must take time to explain any gaps, using flipcharts or models extensively.
- » The counselor should discuss the relationship between contraceptive methods and sexuality, even if men are hesitant to raise it. Men often have serious misconceptions about how condoms, vasectomy, withdrawal, and fertility awareness methods affect sexual performance and pleasure. For instance, they may believe that vasectomy is the same as castration.
- » A man's concerns about his partner's use of contraception may be linked to concerns about sexuality (for example, that the partner will become frigid or promiscuous). Exploring these feelings and giving accurate information about the effects of different contraceptives will help clarify these issues.

- » Not all men know how to use condoms. The counselor should demonstrate and explain how to use a condom by placing it on a realistic model and also by showing the man how to remove it.
- » For men who do not want to discuss family planning, condoms can be placed at various locations in the health facility so men can pick them up without having to ask for them.
- » Health care providers often need to set up a special place and hours to accommodate men's needs for privacy.
- » When possible, the counselor includes the man's partner in the counseling session.

13-3: Postabortion Women*

- **Counseling needs:**

- » A woman who has just had an abortion is likely to be most concerned about her health and the abortion procedure. She may or may not be interested in discussing contraception, and her wishes must be respected.
- » The woman may not be thinking about resuming sexual activity and needing contraceptive protection.
- » The woman may be frightened, sedated, or in pain.
- » Stress is likely to be greatest when a woman comes to the health facility for emergency treatment for an incomplete abortion.
- » The woman may be feeling guilty, particularly if she induced the abortion herself.
- » The woman may be worried that her efforts to terminate her pregnancy will be discovered.
- » Women who have just had an abortion may be especially concerned about confidentiality.
- » A woman who became pregnant because her method failed may be distrustful of contraception.
- » Women often do not realize that their fertility will return soon after abortion. A woman can ovulate within two weeks after an abortion.

- **Suggestions for counseling postabortion women:**

- » Acceptance of contraception must not be a prerequisite for abortion services or treatment of abortion complications.
- » Depending upon the receptivity of the woman, counseling about family planning can be offered to the client before the abortion, while she is in the health facility after abortion, or at the follow-up visit.
- » The counselor approaches the woman at a quiet time when a private discussion is possible. The woman should not be sedated or experiencing considerable pain.

* This handout does not discuss clients who have had a spontaneous abortion (miscarriage).

- » The counselor ensures that the client understands she can become pregnant again before she has her next period.
- » The counselor avoids moralizing about the unintended pregnancy or about the woman's decision to have an abortion.
- » If the woman is not interested in talking about contraception, the counselor can give her referral information so that she can seek out contraceptive services at a later time or return if she is interested.
- » The counselor needs to determine whether the pregnancy was the result of contraceptive failure, since this may influence the woman's interest in using contraception or the information she may need to use a method effectively.
- » For women who do not want to discuss family planning, condoms and spermicides can be placed at various locations in the health facility so women can pick them up without having to ask for them.

13-4: Unmarried Adolescents

- **Counseling needs:**
 - » Adolescents undergo physical, emotional, and hormonal changes that influence their sexuality.
 - » Adolescents' sexual activity is often unplanned and infrequent.
 - » Adolescents are risk takers and often believe that unfortunate events happen to other people, not themselves. With respect to sexuality, adolescents often take emotional risks as well as risks related to pregnancy and STDs.
 - » Adolescents may deny that they are sexually active (especially girls, as this may not be acceptable in their culture or family). For this reason, they may not want to plan for sexual activity by acquiring contraception. They may find it easier to accept sexual activity if it "just happens."
 - » Adolescents' sexual activity is often based on needs outside of sex—for instance, their need for approval or affection.
 - » Adolescents are particularly susceptible to peer influences.
 - » Some adolescents want to get pregnant.
 - » Unmarried adolescents tend to be particularly concerned about privacy. They may be afraid to go to a family planning clinic for fear they will see someone they know there.
 - » Adolescents worry that their parents or friends will find out that they are using contraception.
 - » In many cultures, it is unacceptable for young unmarried men and women to go to family planning clinics.

- **Suggestions for counseling unmarried adolescents:**
 - » Adolescents may be most comfortable with methods that are unlikely to be detected (such as Norplant implants, IUDs, or injectables), that are used only at the time of sexual intercourse (such as condoms or spermicides), or that are easily obtained (such as condoms).
 - » Health care providers often need to set aside special places or times to accommodate adolescents' needs for privacy.
 - » Adolescents can be counseled in places where they gather, such as schools, clubs, or community centers.

- » Adolescents can be trained to serve as peer educators.
- » The counselor does the following:
 - Helps adolescents understand that they will be sexual beings their whole lives; they do not have to try, understand, or perfect everything now.
 - Avoids harsh moralistic lessons against sex.
 - Presents realistic views of relationships, marriage, and parenthood.
 - Helps adolescents who are not ready for sex learn how to say no. Role playing or practicing conversations can be an effective way to do this.
 - Fills in gaps in adolescents' knowledge about reproduction and sexuality.
 - Is prepared to listen to or raise issues about adolescents' sexuality: self-esteem, appearance, being "normal" within the peer group, pressure from peers or partners.
 - Makes condoms easily available, even for those who do not receive counseling.

13-5: Assessing Individual Needs

Case 1: Anne and Elizabeth

Anne just had her first child. She had a difficult delivery. Elizabeth just had her sixth child. She had an easy delivery.

Case 2: Edith and Ruth

Edith is 17 years old. She was not using a contraceptive method when she became pregnant. Ruth is 25 years old and is pregnant. She and her husband planned this baby.

Case 3: Brian and George

Brian is 18 years old, unmarried, and has no children. He is interested in being with different girls. George, 32 years old, is married and monogamous. He and his wife have the four children they want.

14-1: Counseling: Problems and Possible Solutions

Problems	Possible Solutions
No space or inadequate space	<ul style="list-style-type: none"> • Ask the supervisor or director to arrange an adequate private space. • See if it is possible to use other areas of the facility, including outdoor spaces. • If no alternatives can be found, try to arrange the furniture and setting to create as much privacy as possible.
Overworked personnel	<ul style="list-style-type: none"> • Rearrange task assignments. • Use trained volunteers.
Clients required to return on several different occasions	<ul style="list-style-type: none"> • Determine whether scheduling of repeat client visits is needed. See whether any can be combined (or eliminated, if unnecessary).
Interruptions	<ul style="list-style-type: none"> • Create a system to handle interruptions and stick to it. For example, have someone take messages. • Keep the door closed. • Post a sign on the door saying "Please do not interrupt unless urgent." • See people in order of arrival.
Lack of client informational materials, such as pamphlets or audiovisual materials	<ul style="list-style-type: none"> • Use available references to develop simple materials; for example, <i>Talking with Clients about Family Planning</i>. • Often supplies have run out, but materials are available elsewhere. Ask about resupply or reprinting if good materials are known to exist.
Other staff view family planning counseling as specialized	<ul style="list-style-type: none"> • Provide orientation to other staff on what counseling is. • Arrange for these staff, one at a time, to observe counseling. Ask for the client's permission before allowing an observer to sit in. • Integrate counseling into other services.

Counseling: Problems and Possible Solutions (continued)

Problems	Possible Solutions
Staff confused about the differences between motivation, information-giving, and counseling	<ul style="list-style-type: none"> • Orient staff to the differences between these forms of communication and the role of each.
Limited time for counseling	<ul style="list-style-type: none"> • Provide basic information about family planning in group sessions. • Conduct client flow analysis to see whether staff time can be used more efficiently. • Lengthen clinic hours or increase clinic days. • Train and orient more workers.
Unfamiliar local languages or dialects	<ul style="list-style-type: none"> • Train local personnel who speak the languages to do counseling. • Use an interpreter if needed. • When hiring new staff, look for someone who speaks the languages.
Health care personnel or other team members unconvinced of the value of counseling	<ul style="list-style-type: none"> • Provide orientation to other staff on what counseling is and why it is important.
Rumors about family planning circulating in the community	<ul style="list-style-type: none"> • Try to understand how the rumors have developed. Correct false information. • Provide balanced information about family planning. • Work with others in the community (for example, other health care providers and outreach workers) to address rumors. • Address rumors in counseling.
Hesitant or doubtful client	<ul style="list-style-type: none"> • Create an atmosphere of trust. Try to put client at ease. • If client is accompanied by others (such as family members or spouse), find a way to talk to client alone. • Give the client time to think about what she or he has heard.

I4-2: My Commitment to Improve Counseling

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