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Counseling and Communicating with Men

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Counseling and Communicating with Men

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440 Ninth Avenue

New York, NY 10001 U.S.A.

Telephone: 212-561-8000

Fax: 212-561-8067

e-mail: info@engenderhealth.org

www.engenderhealth.org

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For more information, contact:

Manisha Mehta

Program Manager, Men As Partners

EngenderHealth

440 Ninth Avenue

New York, NY 10001 U.S.A.

212-561-8394

e-mail: mmehta@engenderhealth.org

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Introduction

Around the world, women carry a disproportionate amount of responsibility for reproductive health. Although women receive the bulk of reproductive health services, gender dynamics can render women powerless. Men often have decision-making power over such matters as sexual relations, family size, and seeking health care. So it is crucial to support equitable partnerships between men and women while also offering men services that enable them to share the responsibility for reproductive health. One way to reach men is through the provision of reproductive health counseling. This critical service, whether it is provided to men alone or to couples, can have a significant impact on men's ability to protect their health as well as the health of their partners.

This text builds on the companion volume *Introduction to Men's Reproductive Health Services*. That text contains information to help sites and health care workers address organizational and attitudinal barriers that may exist when initiating, providing, or expanding a men's reproductive health services program. This text is designed to provide health care workers with the skills and sensitivity needed to interact with, communicate with, and counsel men with or without their partners.

The text is organized into chapters covering the different areas that constitute interacting with, communicating with, and counseling men. After giving an overview of the various interaction, communication, and counseling approaches that can be used with men, the text examines the potential biases that service providers may have against or in favor of men and how these can affect any of the service providers' interactions with male clients. The text then supplies detailed information on a range of men's reproductive health issues to ensure that service providers have the knowledge required to counsel men. Finally, the text focuses on effective techniques for counseling men and couples.

Throughout this text, the term *service providers* will be used to refer to the staff at a health care facility who provide counseling services. Service providers may include doctors, medical officers, nurses, nurses' aides, midwives, medical or surgical assistants, counselors, and health educators. The term *health care workers* will be used to refer to anyone who is associated with a service site. Health care workers may include receptionists, cleaners, drivers, medical staff, paramedical staff, and outreach staff.

1

Counseling and Client-Provider-Interaction Overview

This chapter provides a basic understanding of the various counseling approaches and elements of client-provider interaction that service providers can use with men. It also explores theories of behavior change and examines the role that counseling can play in helping men change their behaviors in order to improve their sexual and reproductive health, as well as that of their partners. A discussion of the characteristics of an effective men's reproductive health service provider concludes the chapter.

A Framework for Working with Men

Counseling is an integral component of a comprehensive effort to meet men's reproductive health needs. Reproductive health programs use many approaches to involve men. Most of these approaches fall into one of four categories:

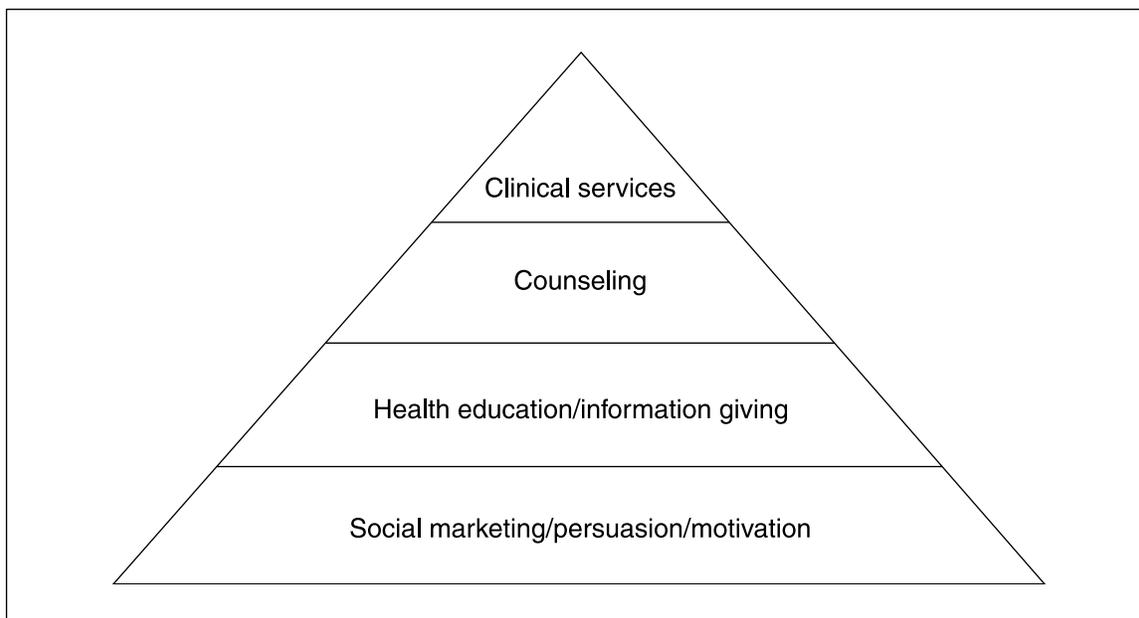
- **Social marketing/persuasion/motivation:** Prompting behavior change in clients by marketing a product, service, or action
- **Health education/information giving:** Transmitting or exchanging information, often in a community setting, to help clients understand the importance of reproductive health issues
- **Counseling:** Exchanging information in a service-delivery setting in order to create awareness of reproductive health issues and help clients confirm or reach informed and voluntary decisions about their reproductive health care
- **Clinical services:** Providing men's reproductive health services in a clinical setting; these include treatment for sexually transmitted infections (STIs), sexual dysfunction, and other disorders of the male reproductive system, as well as vasectomy, fertility evaluation, and cancer evaluation services

Figure 1-1 on page 1.2 provides a visual representation of the relationships among these four approaches.

The four parts of the pyramid indicate the number of clients that benefit from each particular approach and are in a specific order. The number of clients affected by these four approaches is largest at the bottom of the pyramid and gets smaller from bottom to top. For example, social marketing/persuasion/motivation can reach more clients than clinical services can, so it occupies a larger section of the pyramid. The pyramid itself represents the logical progression of a client coming for services. Since social marketing may create interest, the client may then seek information. Once the client has this information, he may seek counseling. If the client receives counseling, he may then decide that a clinical service is necessary.

The variations among the four approaches are shown in the chart on page 1.2.

Figure 1-1. The Relationships among the Four Approaches to Involving Men in Reproductive Health Services



The Differences among the Four Approaches to Involving Men in Reproductive Health Services

Approach	Goal	Content	Direction	Biased or Objective	Example
Social marketing/persuasion/motivation	To influence behavior in a particular direction	Persuasion, focus on benefits	One-way	Biased	Sign or poster that encourages family planning use
Health education/information giving	To provide facts and raise awareness	Facts, skill building	One-way or two-way	Biased or objective	School health talks, informational pamphlets
Counseling	To ensure the clients' informed and voluntary choice	Facts; clients' feelings, needs, concerns	Two-way	Objective	One-on-one discussion about family planning decisions
Clinical services	To provide medical services to clients	Medical services, family planning methods, medication	One-way	Objective	Vasectomy, STI diagnosis and treatment

The following examples demonstrate how the various approaches to working with men can be implemented in a reproductive health program.

Social Marketing/Persuasion/Motivation

- A television advertisement urges men to use condoms.
- A sign or poster shows a photograph of a couple entering a family planning clinic together.
- A radio spot encourages men to bring their wives to a facility for antenatal care.
- A brochure explains how vasectomy can improve men's lives.

Health Education/Information Giving

- A health care worker tells a group of men that their pregnant wives should eat a balanced diet.
- A theater group acts out domestic violence situations and then discusses them.
- A group of young men participate in school programs in which they give talks about preventing HIV or unintended pregnancy.
- A poster explains signs and symptoms of STIs in men.

Counseling

- A doctor responds to a client's concern about vasectomy by explaining that the procedure will not adversely affect his sexual performance.
- A midwife assists a couple living in a village develop a labor and delivery plan.
- A service provider helps a couple assess their risk for HIV.
- A couple talk with a nurse about which family planning method would be best for them.

Clinical Services

- A doctor visits a factory to provide STI diagnosis and treatment to male employees.
- A nurse conducts a digital rectal exam for prostate cancer screening.
- A lab does a fertility workup on a male client.
- A doctor performs a vasectomy.

Client-Provider Interaction (CPI)

Communication has been defined as “a process in which the participants create and share information with one another in order to reach a mutual understanding” (Piotrow et al., 1997). This process can be verbal, nonverbal, visual, and/or written. In a reproductive health setting, communication can occur from the first moment a client meets a health care worker. **Client-provider interaction (CPI)** can be very important in ensuring that the client feels comfortable.

CPI refers to all encounters that clients have with health care workers. These include person-to-person, verbal, and nonverbal communication. Person-to-person communication can be either one-way or two-way. Verbal communication requires words. Nonverbal

communication does not involve words; it can take the form of, for example, a smile, a frown, or a shrug.

Good client-provider interaction involves a two-way exchange between clients and providers. By treating clients respectfully, making them feel at ease, asking nonjudgmental questions, and respecting their personal circumstances, health care workers can focus on clients' specific situations and better meet their needs. In contrast, if a provider gives biased or insufficient information, is not aware of the client's specific needs, fails to ask about a client's previous experiences with reproductive health services, or does not acknowledge their circumstances, the interaction is unlikely to achieve its potential ("Improving interactions with clients," 1999).

Elements of CPI

CPI is an "umbrella" term that includes the following two elements.

Information Giving

Information giving is one-way communication between a service provider and a client. Here, the provider explains a reproductive health issue to the client, or the client tells the provider about a problem that he is experiencing. Information giving can also occur when providers offer health education to clients at the site.

Counseling

Counseling is a specific form of CPI between a service provider and a client. This two-way communication involves a dialogue between a provider and a client. The client discusses his or her needs or concerns, and the provider asks questions to clarify or understand these concerns and provides information to help meet these needs. This type of communication is aimed at creating awareness of reproductive health issues and helping clients confirm or reach informed and voluntary decisions about their reproductive health care and to understand the details of their chosen treatment or method. Counseling also includes asking clients about their needs, informing them of different reproductive health issues relevant to their needs, and explaining their options to them.

Usually, these elements of CPI do not take place independently of each other, but as part of one interaction between a client and a service provider.

Informed Choice

Informed choice is a voluntary, well-considered decision that an individual makes on the basis of options explored, information given, counseling received, and understanding gained during CPI. The client's informed decision must be made free of stress, pressure, coercion, or incentives.

Informed choice should be confirmed and supported in any CPI in which a client needs to make a reproductive health decision. This could include, for example, a client choosing a family planning method, or not knowing which treatment option to pursue for a health problem, or deciding whether or not to accept medical treatment.

Examples of CPI

The following scenarios provide examples of CPI that may occur while providing men’s reproductive health services. The charts highlight whether or not the service provider effectively carried out the two elements of CPI—information giving and counseling—and whether or not the client effectively carried out making an informed choice as a result of CPI.

Note: Some scenarios may involve more than one element and/or result of CPI (indicated by *X*) or none (indicated by *NA* for *not applicable*).

Scenario 1

A childless young man wants to have a vasectomy. The service provider greets him, explains what the procedure involves, talks to him about other contraception options, and discusses his decision not to have children. Based on this information, the young man decides to have a vasectomy.

	Information giving	Counseling	Informed choice
Effectively carried out	X	X	X
Not effectively carried out			

Scenario 2

A client is interested in finding out where the antenatal services in the clinic are provided. She asks the receptionist, who points to a sign.

	Information giving	Counseling	Informed choice
Effectively carried out		NA	NA
Not effectively carried out	X		

Scenario 3

While reviewing the correct steps for putting on a condom, an educator checks to make sure that all the participants understand the procedure by asking some participants to do a condom demonstration in front of the entire group.

	Information giving	Counseling	Informed choice
Effectively carried out	X	NA	NA
Not effectively carried out			

Scenario 4

A clinician supports a young man's struggle to use condoms by helping him feel good about potentially avoiding an STI in the future.

	Information giving	Counseling	Informed choice
Effectively carried out	NA	X	NA
Not effectively carried out			

Scenario 5

A service provider meets with a man who expresses concern about a rash he has developed in his genital area. The provider asks the client a series of questions about his sexual behaviors and then tells him that his symptoms may indicate that he has an STI.

	Information giving	Counseling	Informed choice
Effectively carried out	X	X	NA
Not effectively carried out			

Scenario 6

A worried client comes in searching for the emergency room because his wife is bleeding. The guard on call reassures him and takes him to the emergency room.

	Information giving	Counseling	Informed choice
Effectively carried out	X	NA	NA
Not effectively carried out			

Scenario 7

An educator tells a couple that they should not use natural family planning and gives them a pack of pills to use.

	Information giving	Counseling	Informed choice
Effectively carried out			
Not effectively carried out	X	X	X

Scenario 8

An educator discusses the risks of perpetrating domestic violence, the benefits of gender-equitable relationships, and the advantages of developing skills to improve couple communication with a group of men in a workplace environment.

	Information giving	Counseling	Informed choice
Effectively carried out	X		
Not effectively carried out		NA	NA

Behavior Change

Service providers use different elements of CPI to change individuals' complex behaviors, such as not using condoms. But simply supplying information about harmful behaviors and providing counseling will not adequately create positive behavior change. Various behavior change theories suggest that reproductive health programs must address a range of cognitive, psychological, sociocultural, and structural factors in order to successfully change clients' behavior.

The Social Learning Theory Model of Behavior Change

The following six elements of behavior change are based on Albert Bandura's Social Learning Theory (Bandura, 1977). All of these factors play a role in determining whether or not a person is able to change his or her behavior.

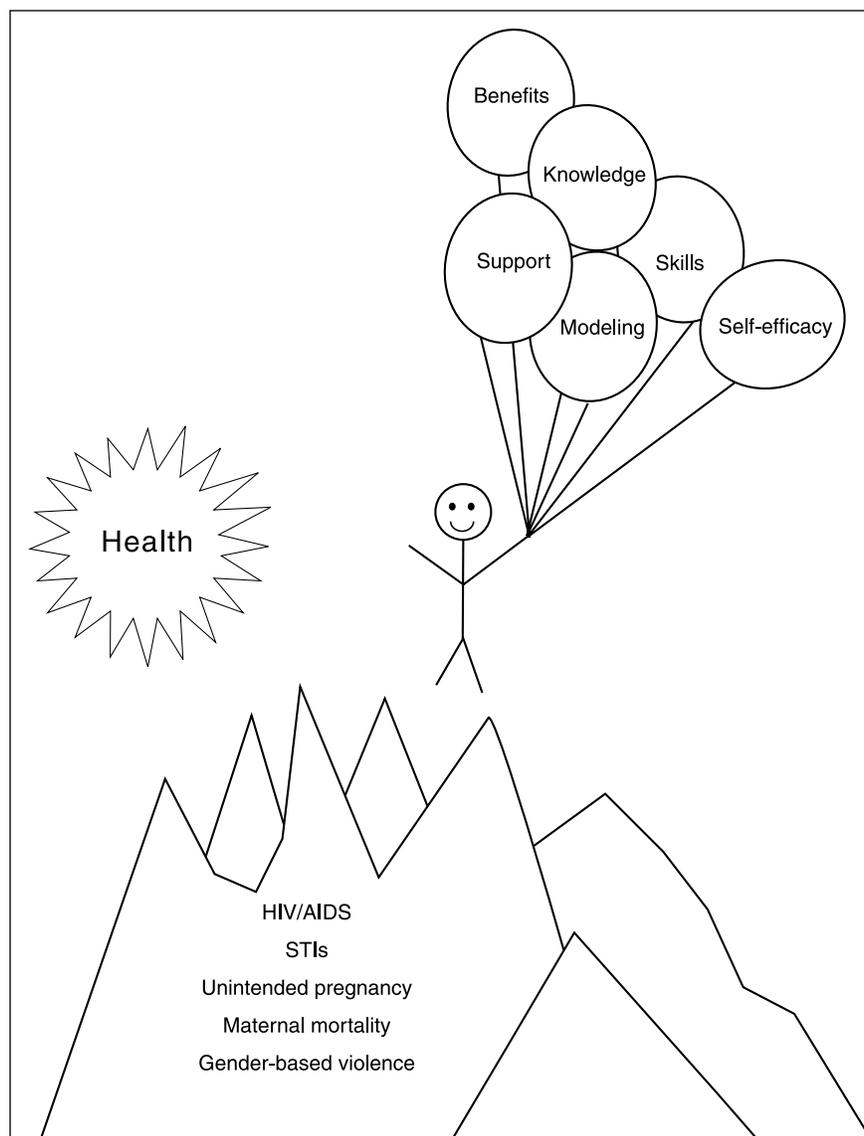
- **Knowledge.** People need to receive consistent factual messages about health issues. Individuals also need to identify myths and misconceptions that may exist about a particular health issue. Through knowledge, individuals should feel that they know how to effectively avoid a health problem.
- **Skills.** People must be able to apply knowledge to their personal lives. This requires skills. Individuals require communication skills to express their health concerns and needs to a partner. Individuals also require practical skills, such as the ability to correctly use a condom.
- **Benefits.** People must understand and believe that there are benefits to a particular behavior. The behavior has to be worth doing. People are often more influenced by the benefits they receive from a particular behavior than by the negative consequences the behavior might cause.
- **Modeling.** Social norms or "rules" influence behavior. People are more likely to do a certain behavior if others whom they associate with also perform that behavior. Therefore, modeling can either support healthy behavior change or hinder it. For example, a person will be more likely to use drugs if his friends use them. A person will be less likely to use drugs if his friends are opposed to drug use.
- **Self-efficacy.** People need to believe that they can actually control their behavior and effectively perform their desired behavior. For example, a young man needs to know that he has the knowledge to effectively and correctly use a condom.

- **Support.** People need help, support, or encouragement to maintain their health. Services must be provided so that people can prevent health problems from occurring. Families can also help an individual via emotional, physical, or economic support.

Figure 1-2 illustrates how the six components of social learning theory influence behavior change. The mountains represent some of the reproductive health problems that an individual would want to avoid. These include HIV/AIDS, STIs, unintended pregnancy, maternal mortality, and gender-based violence.

The person to the left of the mountains needs to pass over these mountains of challenges in order to arrive at “health” on the other side. To do so, he or she needs to use balloons to carry him or her over the mountains. Just having one balloon will not suffice. The individual needs most, if not all, of the balloons to cross the mountains.

Figure 1-2. The Social Learning Theory Model of Behavior Change

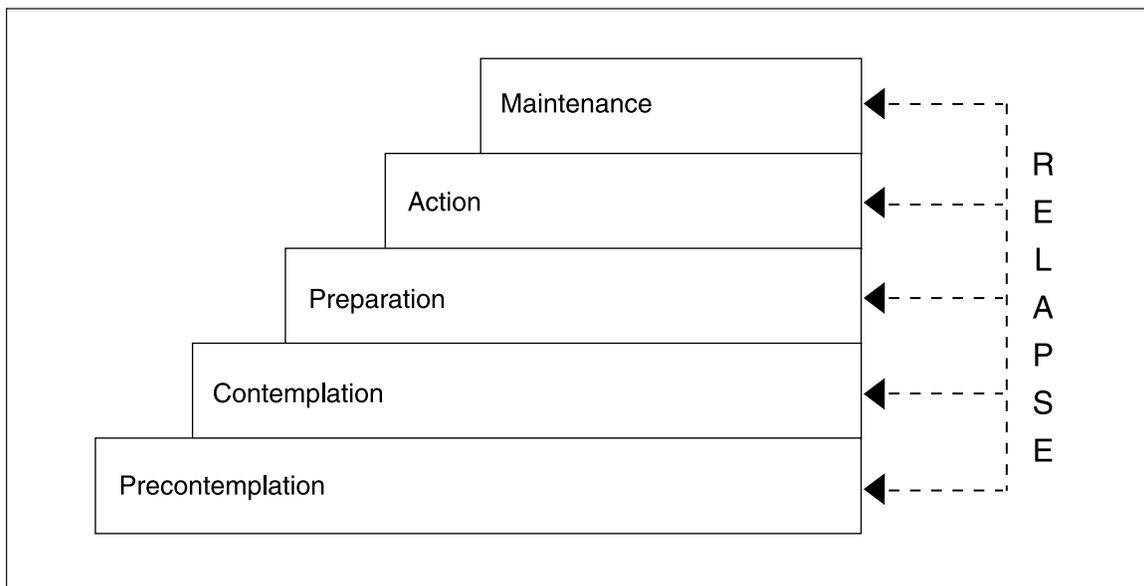


The Transtheoretical Model of Behavior Change

Prevention of high-risk reproductive health behaviors often requires clients to make drastic, immediate changes in their behavior that they may not be able to successfully implement. Rather than expecting clients to make great changes quickly, it may be more useful and realistic to encourage clients to take incremental steps toward altering their behavior.

The transtheoretical model, shown in Figure 1-3, describes behavior change as a process involving progress through a series of five definite stages, as well as a sixth potential stage (Velicer et al., 1998).

Figure 1-3. The Transtheoretical Model of Behavior Change



Source: Adapted from Velicer et al., 1998.

Precontemplation

In this stage, people do not intend to take action in the foreseeable future, which is usually measured as the next six months. Individuals may be in this stage because they are uninformed or under-informed about the consequences of their behavior. Another possibility is that they may have tried to change a number of times and become demoralized about their inability to alter their behavior. People in this stage tend to avoid reading, talking, or thinking about their high-risk behaviors.

Contemplation

This is the stage in which people intend to change in the next six months. They are more aware of the benefits of changing, but they are also acutely aware of the drawbacks. This balance between the advantages and disadvantages of changing can produce profound ambivalence, which, in turn, can keep people stuck in this stage for long periods of time.

Preparation

In this stage, people intend to take action in the immediate future, which is usually measured as the next month. Typically, they have taken some significant action in the past year.

These individuals have a plan of action, such as joining a health-education class, consulting a counselor, talking to their doctor, reading a brochure, or relying on a self-change approach to their behavior.

Action

This is the stage in which people have made specific modifications in their lifestyles within the past six months. These behavior changes may be temporary, and the risk of relapse or failure is high.

Maintenance

In this stage, people are less tempted to relapse and are increasingly more confident that they can sustain their behavior change.

Relapse

This is the stage that potentially follows failure. When this occurs, a person may return to any of the preceding stages.

The Role of Counseling in Behavior Change

Counseling can play an important role in supporting clients' efforts to promote positive behavior change. Counseling sessions help clients:

- **Perceive their risk:** This behavior change involves determining and perceiving their individual risk for HIV or another STI, as well as their risk for becoming pregnant. Service providers can help clients perceive their risk not only by providing information about transmission and risks, but also by exploring the clients' and their partners' specific sexual practices and sexual history.
- **Make decisions and plans:** This behavior change calls for making an informed decision about contraceptive use and disease-prevention options. This choice should include the option of wearing condoms alone (using condoms for protection against pregnancy and STIs/HIV) or dual-method use (using condoms for disease prevention, as well as another contraceptive method or emergency contraception to protect against pregnancy). Service providers can help clients by encouraging them to make certain decisions or to plan certain actions.
- **Develop skills:** This behavior change requires developing skills regarding correct condom use, other safer-sex practices, and sexual-negotiation strategies. Service providers can help clients by teaching them the skills they need for correct condom use or sexual-negotiation strategies.

EngenderHealth's Approach to Counseling

Clients usually come to a facility when they are experiencing a reproductive health problem, need to make a reproductive health decision, or need information about a specific reproductive health issue. Counseling is often part of CPI and is an essential process in

helping clients identify their problems, find solutions, and make decisions that are best for them. Counseling is always responsive to each client's individual needs, concerns, and values.

Counseling goes beyond just giving facts, though; it enables clients to apply information about reproductive health to their particular circumstances and to make informed choices. It also includes a discussion of the client's needs, feelings, and concerns regarding reproductive health. Counseling *always* includes two-way communication between the client and the service provider, in which each spends time talking, listening, and asking and answering questions.

For reproductive health counseling to be effective, service providers must:

- Create an atmosphere of privacy, respect, and trust
- Engage in two-way communication with the client
- Remain nonjudgmental and open to offering the client options
- Be empathetic to the client's needs
- Feel comfortable addressing sexual and gender issues
- Remain patient during CPI
- Provide reliable and factual information
- Respect the client's rights

The Rights of Clients

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

Access to Services: Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination that is based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.

Informed Choice: Clients have a right to make a voluntary, well-considered decision that is based on options, information, and understanding. The informed choice process is a continuum that begins in the community, where people get information even before coming to a facility for services. It is the service provider's responsibility to either confirm an informed choice that a client has made or help the client reach an informed choice.

Safe Services: Clients have a right to safe services, which require skilled service providers, attention to infection prevention, and appropriate and effective medical practices. Safe services also mean proper use of service-delivery guidelines, quality-assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

Privacy and Confidentiality: Clients have a right to privacy and confidentiality during delivery of services. This includes privacy and confidentiality during counseling, physical examinations, and clinical procedures, as well as in staff's handling of clients' medical records and other personal information.

Dignity, Comfort, and Expression of Opinion: All clients have the right to be treated with respect and consideration. Service providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, even when their views differ from those of service providers.

Continuity of Care: All clients have a right to continuity of services, supplies, referrals, and follow-up necessary to maintain their health.

2

Addressing Provider Bias and Needs

This chapter reviews the anxieties and/or negative feelings that health care workers may have about providing services to men, which can affect how staff interact with male clients, in order to help you understand and address them. This chapter also addresses facility bias toward serving men and the way in which making simple service-delivery changes can overcome this.

Understanding and Overcoming Provider Bias

Service providers and other health care workers bring their own attitudes, biases, and perceptions to their interactions with clients, and these attitudes can negatively affect their ability to provide adequate health care services. Some staff may feel conflict between their duties to help clients achieve sexual and reproductive health and their own morals, beliefs, and values.

In order for service providers to offer quality services, it is critical that they do not let their own attitudes about sexuality and sexual practices keep them from sharing information about the potential health consequences of those practices. Providers must help clients to ensure healthy sexual and reproductive health lives without imposing value judgments on their behaviors. Providers must also address their own gender biases that are specific to interacting with and counseling male clients.

Within men's reproductive health services, provider bias can be directed both against and toward (in favor of) men.

Provider Bias *against* Men

Since many service providers have not had experience or training in working with men, they may hold certain attitudes or biases toward men, especially as reproductive health clients, that may reduce their effectiveness in meeting the clients' needs.

Making Men Feel Uncomfortable and Unwelcome

A service provider's fear, anxiety, ambivalence, or negativity about providing reproductive health services to men may be apparent during interactions with male clients. Such treatment may make men feel uncomfortable and unwelcome at a health care facility. Service providers may hold various beliefs that reinforce the poor treatment of male clients.

For example, providers may believe that:

- Reproductive health care facilities should be for women only, since women have traditionally been responsible for family planning; these facilities offer women a safe space to receive care.

- Within the reproductive health field, service providers' training and mission involve working with women only.
- Providing reproductive health services to men will take away resources from women.
- The presence of men in the health care facility makes female clients feel uncomfortable.
- The presence of men in the health care facility jeopardizes the safety of female clients and/or of the facility itself.
- Male clients will become disruptive, angry, or threatening toward their partners, other female clients, or health care facility staff.
- Men are not interested in reproductive health services, including family planning.
- Men who engage in same-sex sexual activity are immoral or sick and do not deserve to receive sexual and reproductive health services at a facility.
- Men are a part of the “problem,” not the solution, when it comes to reproductive health issues.
- Men will control the communication and decision-making process during their partner's counseling or examination session.
- Men will flirt with or make sexual remarks to female clients or staff members.
- Men will not want to receive health care from female service providers.
- Men will criticize the services they receive or will accuse staff members of being ignorant or incompetent.

Service providers who hold any of these beliefs may struggle to set aside their personal biases when trying to provide professional and respectful reproductive health services to men.

Failing to Provide Accurate Information about Male Contraception and STI Prevention

During reproductive health counseling, service providers must adhere to the principles of informed choice; this requires giving complete, accurate information about all contraceptive and infection prevention methods. Providers must avoid bias, respect clients' preferences over their own, and support the constructive involvement of men in the protection of their own, their partner's, and their family's health.

Some beliefs that lead service providers to omit information while providing reproductive health services to men include the following:

- Men are not interested in receiving information about men's reproductive health services.
- Men will not choose to participate in using a male contraceptive method, including condoms and vasectomy.
- Men cannot be trusted to use condoms consistently and correctly.
- Men will not use condoms at all.
- Men do not care if they have an STI.
- Men's right to live a sexually satisfying life is not important. For example, if men have problems with sexual dysfunction, service providers may not think that is important.

Some providers may omit important reproductive health information to men because they:

- Lack knowledge about male sexuality issues
- Lack knowledge about male contraceptive methods
- Feel uncomfortable talking to men about sexuality issues
- Believe that certain types of male clients are not at risk for HIV or other STIs

- Are prejudiced about a client's or couple's sexual orientation and sexual activities
- Assume that a married couple is monogamous, and feels uncomfortable bringing up the topic of infection protection with married couples
- Wrongly think that they do not need to provide information about infection protection to men who themselves or their partners have undergone sterilization

Both acting in ways that indicate bias and omitting reproductive health information are violations of informed choice practice, and they place a client's sexual and reproductive health at risk.

Violating Male Clients' Privacy and Confidentiality

Since reproductive health care facilities have traditionally been aimed at women, a facility's policies, protocols, and physical environment may affect male clients' privacy and confidentiality.

Examples of service provider behaviors or a health care facility policies that may violate male clients' privacy and confidentiality include the following:

- Providers asking male clients questions in a public space rather than in a separate room that offers privacy and confidentiality
- Providers inappropriately sharing confidential information about a male client's health (to either other clients or other staff), which may lead to the client's discomfort or embarrassment
- Facilities prohibiting fathers from the delivery room either because they fear that men will bring in germs or because they think that men will be more vocal in ensuring that both their needs and their partners' needs are met

Although these violations have underlying attitudinal causes, there are also facility policy and physical environment issues that can be addressed to minimize this type of bias. Many suggestions for increasing the male friendliness of health care facilities can be found in *Introduction to Men's Reproductive Health Services* (see Chapter 6, pages 6.8 and 6.9).

Potential Outcomes of Provider Bias against Men

- Making men feel uncomfortable and unwelcome
- Making assumptions about male clients and their sexual behaviors
- Failing to give accurate information about male contraceptive methods or sexually transmitted infection (STI) prevention
- Violating rights of privacy and confidentiality

Provider Bias *toward* Men

Even though provider bias is often thought to be directed *against* male clients, there is also evidence of provider bias *toward* men (Ringheim, 2001). Research on counseling sessions with women, men, and couples in Kenya (Kim et al., 2000) revealed the following:

- Men were much more likely to ask questions and volunteer information than women.
- Sessions with men and couples lasted more than twice as long as sessions with women.

- Service providers offered men more information, asked fewer questions, and issued fewer instructions than they offered women.
- Service providers always responded supportively to men’s comments and questions but disagreed with or ignored women’s input 28% of the time.

The first finding, that men ask questions and volunteer information more often than women, goes against the traditional notion that men do not ask questions or volunteer information about health-related issues, especially sexuality issues. Although the study does not offer a specific reason for men’s active participation, it is possible that within the context of couples counseling, men may exert their communication and decision-making power. The study does suggest, however, that “men’s higher social standing tends to equalize the relationship between male clients and female providers, and the novelty of serving men encourages providers to give them special treatment” (Kim et al., 2000).

A service provider’s tendency to direct information or pay more attention to male partners than female partners during couples counseling may have several causes, including the following:

- A provider adhering to a cultural norm of directing information to men
- A provider believing a traditional notion that men are decision makers
- A male client exerting power in the relationship

As the Kenyan study illustrates, provider bias toward men, especially in the context of couples counseling, seriously jeopardizes the opportunity to support men as equal partners in reproductive health decision making.

Additional studies indicate that providers may be biased toward men in other ways as well:

- Service providers and male clients alike may share the belief that it is unnecessary to impose sterilization (vasectomy) on men when women can undergo female sterilization (tubal ligation) instead.
- Service providers give information to men about their female partners’ medical condition while neglecting to give this same information to the women themselves.

The sterilization bias discussed above is a classic violation of the informed choice process, as well as a classic example of burdening women with the responsibility of family planning. Training service providers in informed choice and male involvement should address this bias.

In the other example of provider bias, service providers may once again be reinforcing the traditional notion that men are the decision makers. In this situation, providers would require training to ensure that information about a female partner’s medical condition is kept confidential and is shared with her partner(s) only with her permission or when it is required by law.

Because there are many barriers to and biases against men’s participation in reproductive health services, providers must be careful that efforts to involve men do not reinforce traditional gender inequities that threaten women’s health: “Such unintended consequences of involving male partners suggest that serious attention to gender dynamics must be addressed in training” (Ringheim, 2001). Strategies for addressing provider bias toward

men follows here, and detailed information about sensitivity to gender dynamics is provided in Chapter 4.

Potential Outcomes of Provider Bias toward Men

- Omitting information about male contraceptive methods to men or their partners as a way of taking the responsibility for contraception off men
- Providing information about a female client's medical condition to her male partner(s) while not sharing this information with the client herself
- Paying more attention to men and ignoring their partners during couples counseling sessions
- Serving male clients immediately and making female clients wait for services

Techniques for Addressing Potential Provider or Facility Bias during Counseling

Service providers can improve their interactions with clients by becoming aware of their own biases, values, and attitudes and working to prevent them from interfering with their ability to offer nonjudgmental services. Special training techniques can help providers feel more comfortable addressing sexuality with clients and recognize their biases and judgments about clients. Improving client-provider interaction (CPI) will ultimately enable clients to improve their overall reproductive health and will result in higher-quality counseling services.

When addressing provider bias in men's reproductive health services, health care facilities should consider:

- Educating service providers about the reason that international efforts are being made to constructively involve men in family planning and reproductive health, as well as their success in doing so
- Giving providers the opportunity to voice their fears, concerns, and/or biases about counseling men
- Establishing an ongoing forum for providers to share their experiences and lessons learned from working with men
- Establishing safety protocols and procedures for addressing potential negative or dangerous incidents or interactions with male clients
- Training providers in contraceptive methods that require men's participation, including condoms, withdrawal, fertility awareness, and vasectomy
- Training providers in informed consent, making sure that all contraception counseling includes unbiased information about male contraceptive methods
- Sensitizing providers to the tendency to respond more supportively to comments and questions from men than from women during couples counseling sessions
- Ensuring that information about a female client's medical condition is kept confidential and is shared with her male partner only with the woman's permission or when it is required by law
- Creating private space for counseling men that protects their confidentiality
- Training providers to ensure the confidentiality of all clients' medical records

Characteristics of Effective Men's Reproductive Health Service Providers

Some managers of men's reproductive health programs are concerned about their staff's ability to successfully communicate with male clients as individuals or as part of a couple. Experienced professionals from the field define effective men's reproductive health service providers as providers who:

- Demonstrate knowledge about gender, male sexuality, men's sexual and reproductive health, and the connection and impact that gender has on reproductive health (gender norms usually lead men to have more power in society than women do, which has serious implications for reproductive health)
- Explore their own values, attitudes, and perceptions about gender, working with men, and working with couples
- Incorporate a gender perspective in their interactions with clients that supports men's participation in family planning and reproductive health while safeguarding women's reproductive health needs
- Model effective counseling techniques that cater to men's needs and roles as individuals and/or constructively involve men as supportive partners
- Display genuine caring for men's concerns and needs

Factors That May Affect a Service Provider's Ability to Work with Men

A service provider's comfort with sexuality, feelings about gender, and previous training all play a role in how he or she may interact with men as individual clients or as part of a couple. Figure 2-1 on page 2.7 outlines some of the key factors that influence a service provider's ability to work with men as individuals and as partners.

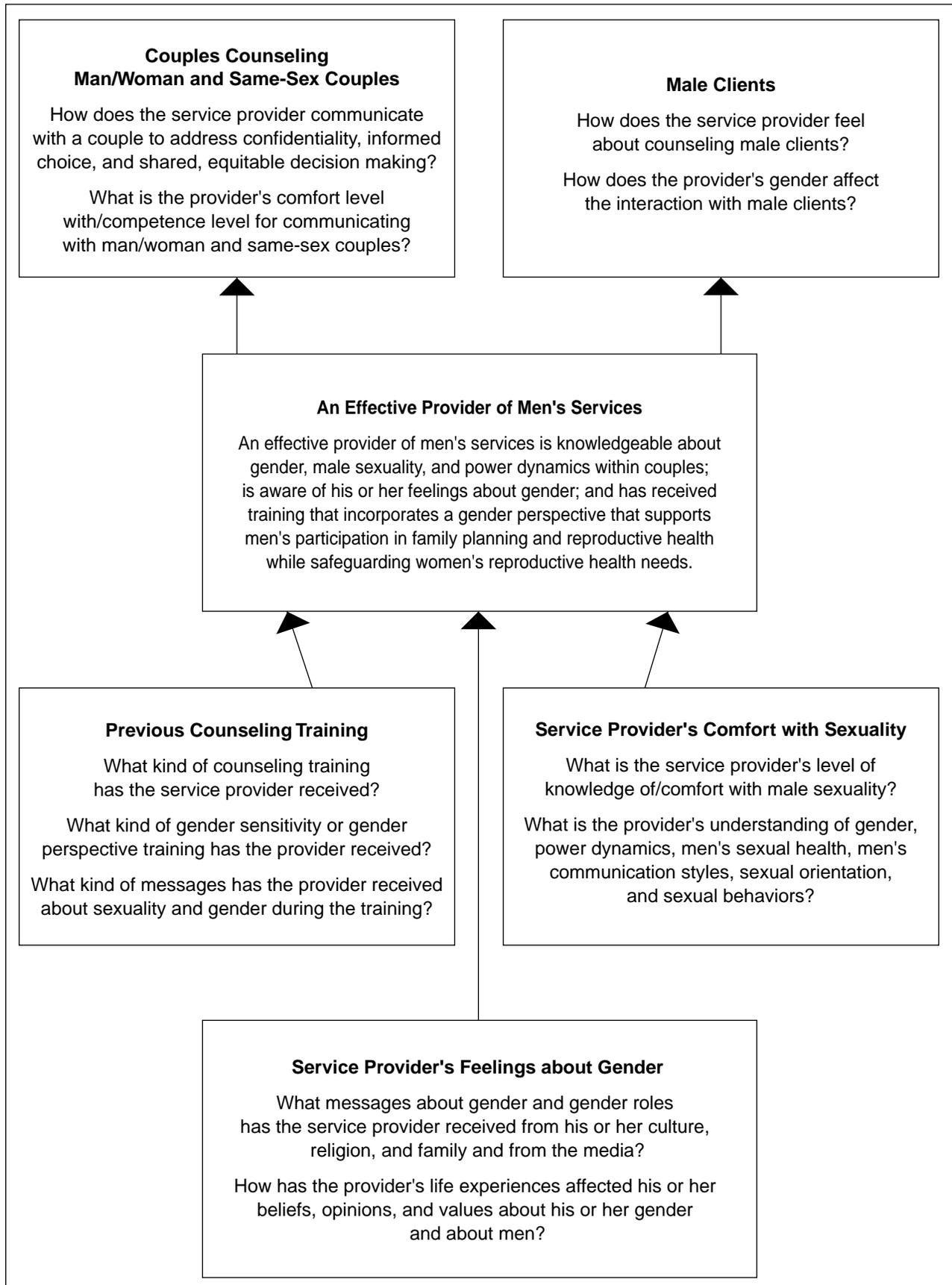
Service Providers' Comfort with Sexuality

One of the first concerns that many service providers have when first working with men relates to their level of knowledge of sexuality, specifically male sexuality and sexual health. In addition to knowledge, providers' attitudes about sexuality affect their comfort and ability to interact with men as individual clients or as partners. Providers must feel comfortable discussing a client's sexual history, relationships, and sexual practices in order to help a client or a couple make healthy decisions. Providers who avoid discussing broader issues of sexuality may rely on assumptions about their client's situation and could possibly put the client at risk.

When working with men or couples, service providers should consider the following important questions (Wilson, Quackenbush, & Kane, 2001):

- How confident am I in my factual knowledge about male sexuality and sexual health?
- Which of my values affect how I feel and think about counseling men on sexuality issues?
- How do my feelings and attitudes about sexuality counseling differ from my male clients'?

Figure 2-1. Factors That May Affect a Service Provider's Ability to Work with Men



- How comfortable and skilled am I in discussing sexuality in ways that my male clients can understand?
- How do I respond when male clients discuss their sexual experiences with me? Can I openly discuss sexual functioning and response?
- While discussing sexuality with male clients, do I avoid asking or answering certain questions because they make me feel uncomfortable?
- What assumptions do I make about sexual behavior or health that may be incorrect or detrimental to clients?
- Does my disapproval of certain sexual behaviors affect the way I counsel and deliver services?
- How do I feel about:
 - Men who have sex with multiple partners?
 - Men who have sex outside the context of marriage?
 - Men who have extramarital sex?
 - Men who have same-sex relationships or engage in same-sex sexual activity?
- How do I respond when male clients ask me personal questions about my sexual experiences?
- How do I feel about couples counseling?
- How do I feel about men's and women's role in decision making about family planning and reproductive health?
- Can I recognize the power imbalances within couples? Can I recognize the signs of sexual violence? Am I sensitive and effective when talking to both victims and perpetrators of sexual violence?

Service Providers' Feelings about Gender

Service providers' feelings about gender and gender roles affect their ability to provide effective counseling services to men and couples. Just like clients, providers have grown up receiving messages about the different roles men and women play in society, the rights and responsibilities attached to these roles, and the inequities women have endured as a result of these roles. These messages affect service providers' life experiences and understanding of gender, and, most likely, affect their beliefs, opinions, and values about men and couples.

Although gender roles and expectations differ within diverse cultures, some values about gender often arise in relation to family planning and reproductive health.

Service providers who are aware of their values about working with men, as well as how these values may affect their interactions with clients and couples, are best prepared to provide effective counseling. One way that reproductive health facilities have successfully addressed their staff's ambivalent or negative feelings about working with men is by setting up staff meetings during which staff can discuss their fears and concerns outside the context of working with clients. Staff are allowed to voice their issues and challenges and receive validation, feedback, and suggestions about how to successfully provide professional and respectful reproductive health services to men and couples.

The Effect a Service Provider’s Gender Has on the Quality of Men’s Reproductive Health Services

There is some debate about what role a service provider’s gender plays in the comfort level of male clients talking to and receiving reproductive health services from a provider and on the provider’s effectiveness in delivering these services. Experienced providers have identified the following key themes:

- Some men feel more comfortable talking to a *male* service provider about sexual health issues and receiving services from a *male* provider; they want to avoid appearing ignorant or being embarrassed in front of a female provider.
- Some men feel more comfortable talking to a *female* provider about sexual health issues and receiving services from a *female* provider; they want to avoid potential homophobic feelings or discomfort when talking to another man about their sexual issues.
- While some men may be initially predisposed to feeling more comfortable talking to and receiving services from a male or a female provider, for most men it is not the provider’s gender that matters but rather his or her level of knowledge, comfort level, and ability to provide professional and respectful care.

The Effect a Service Provider’s Previous Training Has on the Quality of Men’s Reproductive Health Services

Whether a service provider is working with male clients for the first time or has extensive experience working with men, his or her previous training in sexuality, gender, and counseling—as well as the provider clarifying his or her values so that they do not influence his or her interaction with male clients—plays an important role in how he or she approaches working with men as individual clients or as partners. Although previous training affects a provider’s skills and readiness to work with individual male clients and with couples, it is also important to consider the values underlying any prior training, even if that training did not specifically address gender, sexuality, or men’s issues. Prior training that did *not* indicate specifically or imply that men’s participation improves reproductive health for the men themselves, their partners, and their families may negatively affect a service provider’s future work with male clients and couples. The most knowledgeable and skilled provider in male sexuality and sexual health will not be able to provide quality counseling to men if he or she does not have a positive attitude toward men and the role they can play in improving their own health, as well as that of their partner(s) and family. This is why any current or future training of staff who work with men should include not only knowledge and skill building, but also a component to enable staff to clarify their values, attitudes, perceptions, fears, concerns, and biases.

3

Men's Sexual and Reproductive Health Overview

This chapter provides basic information about men's sexual and reproductive health issues, including:

- Sexuality
- Men's sexual and reproductive anatomy and physiology
- Sexual dysfunction
- Sexual behaviors
- Sexual orientation
- Contraceptive methods
- Condoms
- Common sexually transmitted infections (STIs)
- Cancers of the reproductive system
- Infertility

This information will increase your comfort with and understanding of these topics, thus enabling you to provide appropriate and effective reproductive health services to men.

Defining Sexuality

This section provides an introduction to sexuality, including gender roles, sexual orientation, sexual development, sensuality, and sexual behaviors. These topics are essential to understand because they can significantly influence client-provider interaction, including during counseling.

Sexuality is an expression of who we are as human beings—a total sensory experience involving the mind and body. Sexuality includes all the feelings, thoughts, and behaviors of being male or female, being attractive and being in love, as well as being in relationships that include intimacy and physical sexual activity.

Sexuality begins before birth and lasts throughout the course of the life span. A person's sexuality is shaped by his or her values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, spiritual selves, and all the ways in which he or she has been socialized. Consequently, the ways in which individuals express their sexuality are influenced by ethical, spiritual, cultural, and moral factors.

Sexuality Is More than Sex

Often, people confuse the terms **sex** and **sexuality**. While sex is part of sexuality, **sex** and **sexuality** are not the same. **Sex** refers to one's biological characteristics—**anatomical** (breasts, vagina; penis, testes), **physiological** (menstrual cycle; spermatogenesis), and **ge-**

netic (XX; XY)—as a male or as a female. **Sex** is also a synonym for **sexual intercourse**, which includes penile-vaginal sex, oral sex, and anal sex.

The Four Components of Sexuality

Sexuality involves many aspects of being human. Figure 3-1 on page 3.3 shows the four major components of sexuality: sensuality, intimacy and relationships, gender identity, and sexual health. Each of these components is greatly influenced by an individual's values, culture, and spirituality. The four components of healthy sexuality can be adversely affected by using sexuality to control others. This behavior can be seen at the corner of the diagram.

The four major components of sexuality can be defined as follows:

Sensuality

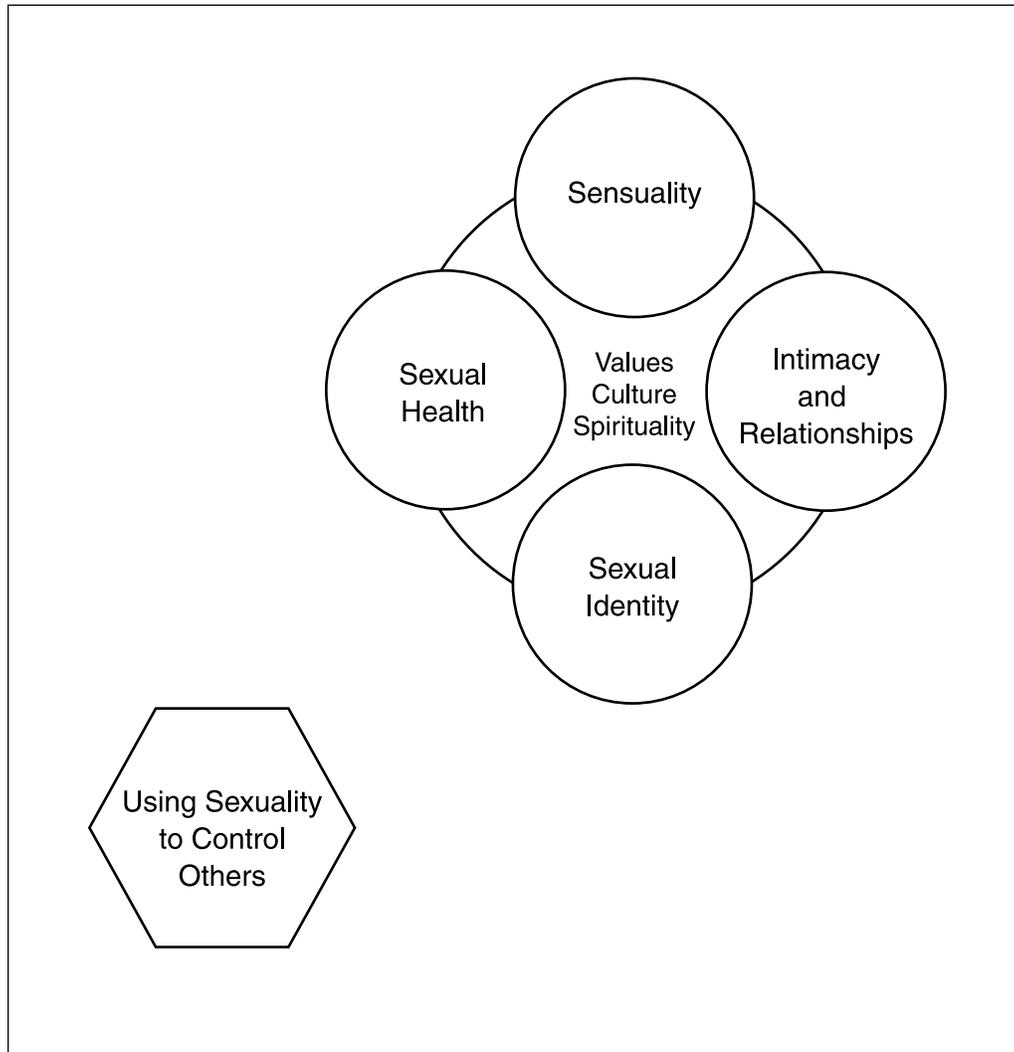
This is how our bodies derive pleasure. It is the part of our body that deals with the five senses: touch, smell, sight, hearing, and taste. When enjoyed, any of these senses can be sensual:

- **Touch:** Our entire bodies are sensitive to touch and pressure.
- **Smell:** Some species of animals emit **pheromones**, which are chemical substances that attract sexual partners. We may find some aromas, scents, or smells pleasurable and sexually arousing, too.
- **Sight:** This can play a role in our attraction to another individual. Our preferences for specific visual sights or erotic stimuli may vary by sex and from person to person.
- **Hearing:** Some people report that certain types of poetry, music, or other kinds of sounds can raise their level of sexual arousal. Sometimes, hearing specific phrases or the sound of someone's voice may be arousing.
- **Taste:** Some people believe that certain foods may stimulate sexual arousal. For example, chocolate contains endorphins. These proteins can create a sense of calm and good feeling, thereby potentially making a person feel more relaxed for sexual activity.

The sexual-response cycle is also part of our sensuality because it is the mechanism that enables us to enjoy and respond to sexual pleasure. This cycle consists of five main stages:

1. **Desire** (also called **libido**): This stage, in which a man or woman begins to want or "desire" sexual intimacy or gratification, may last anywhere from a moment to many years.
2. **Excitement** (also called **arousal**): This stage, which is characterized by the body's initial response to feelings of sexual desire, may last from minutes to several hours.
3. **Plateau:** This stage, which is the highest point of sexual excitement, generally lasts between 30 seconds and three minutes.
4. **Orgasm:** This stage, which is the peak of the plateau stage and the point at which sexual tension is released, generally lasts for less than a minute.
5. **Resolution:** The duration of this stage, which is the period when the body returns to its pre-excitement state, varies greatly and generally increases with age.

Figure 3-1. The Four Components of Sexuality



Our body image is another part of our sensuality. Whether or not we feel attractive and proud of our bodies influences many aspects of our lives.

Fantasy is part of our sensuality, too. Our brain gives us the capacity to fantasize about sexual behaviors and experiences without having to act upon them.

Intimacy and Relationships

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

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

Sexual Identity

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

1. **Biological sex** is based on our physical status of being either male or female.
2. **Gender identity** is how we feel about being male or female. Gender identity starts to form around age 2, when a little boy or girl realizes that he or she is different from the opposite sex.

Our gender identity is at the core of how we feel about who we are. Some people are biologically male but internally feel female, and vice versa—these people may never feel comfortable living as defined by the sex they were born with.

If a person feels like he or she identifies with the opposite biological sex, he or she often considers himself or herself to be transgender. In the most extreme cases, a transgender person may have an operation to change his or her biological sex so that it can correspond to his or her gender identity.

3. **Gender roles** are norms established by society that tell individuals how to behave based on their biological sex. Society has clear expectations about how males and females should behave. From the moment we are born, we are treated and expected to behave differently based on our biological sex.
4. **Sexual orientation** is the final element of sexual identity. Sexual orientation refers to the biological sex that we are attracted to romantically. Our orientation can be **heterosexual** (attracted to the opposite sex), **bisexual** (attracted to both sexes), or **homosexual** (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. Actually, however, the man and woman are expressing different gender roles. Their masculine or feminine behavior, respectively, has nothing to do with their sexual orientation. Homosexual men may be very feminine, very masculine, or neither. The same applies to heterosexual men. Also, a person may engage in same-sex behavior and not consider him- or herself homosexual. For example, men in prison may have sex with other men but may consider themselves heterosexual.

The range of sexual orientation, from heterosexuality to homosexuality, is a continuum. Most individuals' sexual orientation falls somewhere along that continuum. While scientific studies have shown that individuals cannot change their sexual orientation at will, sexual orientation may change over time. Scientific research has also shown that individuals who have sex with members of their own sex can be just as emotionally healthy as those who have sex exclusively with members of the opposite sex.

Sexual Health

This involves our behavior related to producing children, enjoying sexual behaviors, and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy, and sexually transmitted infections (STIs) are part of our sexual health.

According to the Programme of Action from the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994, “sexual health is part of reproduc-

tive health and includes healthy sexual development; equitable and responsible relationships and sexual fulfillment; and freedom from illness, disease, disability, violence, and other harmful practices related to sexuality” (Programme of Action 7.3, 7.6).

A Fifth Component Related to Sexuality

Using Sexuality to Control Others

Generally, this component is not considered to be an aspect of sexuality but as something that can cast a shadow over a person’s healthy sexuality. Using sexuality to control others is not healthy. Unfortunately, many people use sexuality to violate someone else or get something from another person. Rape is a clear example of using sex to control somebody else. Sexual abuse and forced prostitution are others. Even advertising often sends messages of sex in order to get people to buy products.

Men’s Sexual and Reproductive Anatomy and Physiology

This section provides an overview of the male reproductive system. Specifically, it provides information about men’s sexual and reproductive anatomy and physiology, including erection and ejaculation. This important background information will enable you to better understand various male reproductive health issues.

Communicating with Clients about Sexual Anatomy and Behaviors

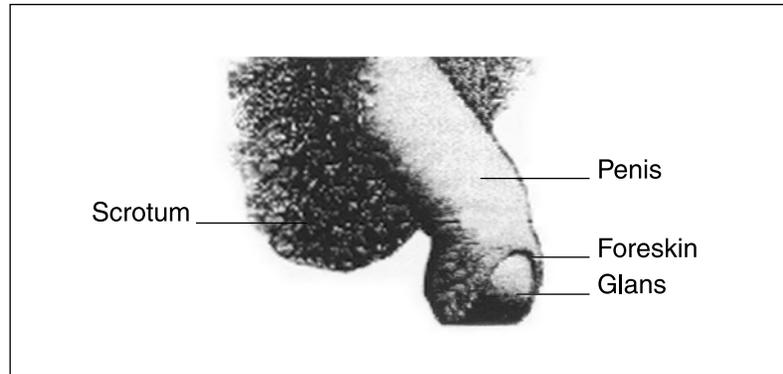
In this section, explicit terms are used to describe sexual organs, sexual function, and sexual behaviors. Many people, including service providers, are uncomfortable using slang and sometimes use medical terms for sexual anatomy and behaviors. Male clients coming to a health care facility seeking information about services may use common, slang, or colloquial terms to describe their bodies, sexual behaviors, and sexual function. Therefore, it is important for service providers to understand both the medical and the common or slang terms used in their local area and to be comfortable hearing (and perhaps using) common or slang terms in order to communicate effectively with clients.

Service providers have several ways to help clients learn and use the medical terms. For example, a provider might say to a client, “You have a sore on your dick? Oh, another word for **dick** is **penis**. I will probably call it a penis more often, but it means the same thing.” In this way, the client learns the correct term without feeling criticized or unknowledgeable for having used the slang term.

Medical terms that you may hear at your facility include:

- **Body parts:** penis, scrotum, testes/testicles/male gonads, clitoris, vagina, breasts, anus
- **Sexual behaviors and related terms:** erection, masturbation, sexual intercourse, penile-vaginal sex, oral sex (**fellatio** when performed on a man; **cunnilingus** when performed on a woman), anal sex, withdrawal, ejaculation, orgasm, condom, impregnate

Figure 3-2. External Male Genitals



Overview of the Male Reproductive System

External Male Genitals

As shown in Figure 3-2, the external male genitalia are the penis, the glans, the foreskin, and the scrotum.

The **penis** is a tubular structure with the capacity to be flaccid or erect; it is very sensitive to stimulation. The head of the penis, the **glans**, includes the most highly innervated, or sensitive, part of the penis and is covered by the **foreskin** in men who are not circumcised. The penis provides passage for both urine and semen.

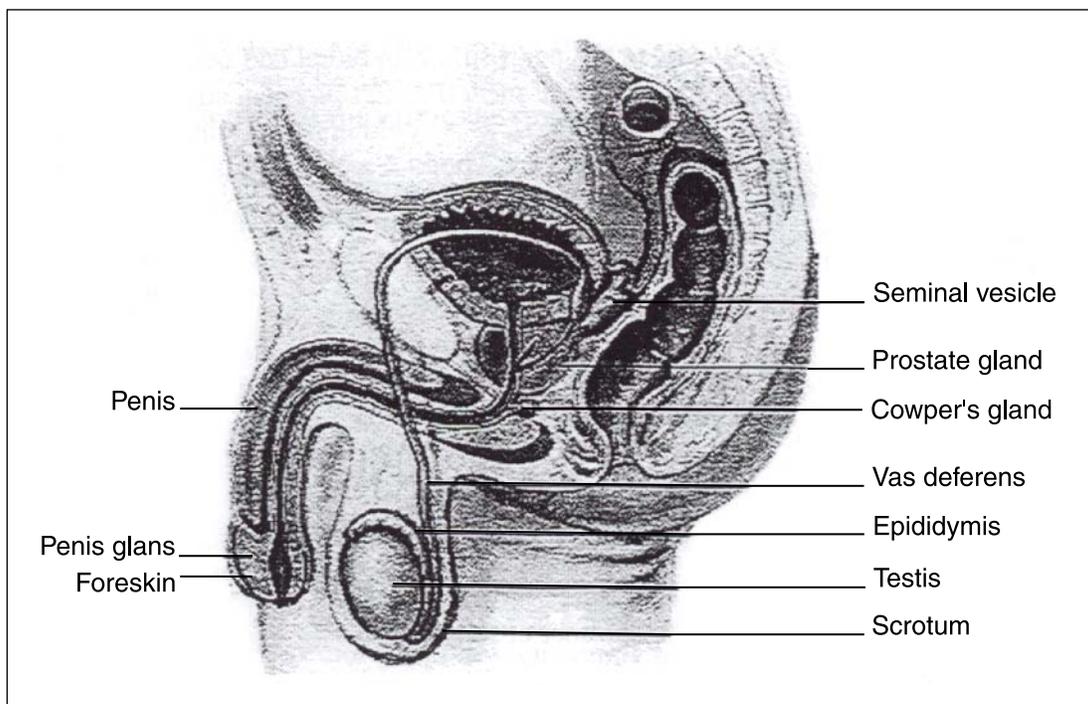
As is the case with other human characteristics, adult penis size and shape vary. The size of a penis when it is flaccid does not predict what size it will be when it is erect. Most men have an erect penis length in the range between 12 and 18 cm (5 to 7 inches), roughly the same as the length of most women's vaginas. Some variation also occurs in penis diameter. Average diameter (width) of an erect penis is 4 cm (1.6 inches).

Although concern about penis size is common, true **microphallus**, or abnormal smallness of the penis, is rare. To assess the normality of penis size, the **stretched penile length** of a flaccid penis is determined. Microphallus is defined as a stretched penile length of less than 4 cm (1.6 inches) for prepubertal boys or less than 10 cm (4 inches) for adult men.

Male circumcision is the surgical removal of the foreskin, the skin that covers the glans of the penis. Circumcision is a common practice in many countries. The medical benefits of circumcision are debatable, although some studies show lower rates of urinary tract infections among circumcised boys. However, since these infections are relatively uncommon and easily treated, it is unclear whether circumcision is a reasonable preventive measure. Current studies are looking at the relationship between circumcision and transmission of STIs. In low-resource settings in which circumcision is performed without proper medical training, risks associated with the procedure include tetanus infection, severe blood loss, disfigurement, and even death.

The **scrotum** is a pouch hanging directly under the penis that contains the testes. The scrotum both protects the testes and contracts to raise or lower the testes toward and away from the body in order to maintain the optimal temperature for sperm production within the scrotum, 34°C (93°F).

Figure 3-3. Internal Male Genitals



Internal Male Genitals

As shown in Figure 3-3, the internal male genitals are the testes, the epididymides, the vasa deferentia, the seminal vesicles, the prostate gland, and the Cowper's glands.

The **testes**, which are located in the scrotum, are the paired organs that produce sperm and male sex hormones. They are highly innervated and sensitive to touch and pressure. The testes produce testosterone, which is the hormone responsible for the development of male sexual characteristics (a man's deepened voice and prominent facial hair) and sex drive (libido). The **epididymides** (singularly, an **epididymis**) are the two highly coiled tubes against the back of the testes where sperm mature and are stored until they are released during ejaculation. The **vasa deferentia** (singularly, a **vas deferens**) are the paired tubes that carry the mature sperm from the epididymis to the urethra.

The **seminal vesicles** are the pair of glandular sacs that secrete some of the fluid that makes up semen, the white, milky fluid in which sperm are transported. Seminal fluid provides both the medium for transport of and nourishment for the sperm. The **prostate gland** is a walnut-sized glandular structure that also secretes fluid that makes up semen. A muscle at the bottom of the prostate gland keeps sperm out of the urethra until ejaculation, the process of releasing semen, begins. This same muscle also keeps urine from coming out during ejaculation. The prostate gland is very sensitive to stimulation and can be a source of sexual pleasure. (More information about the prostate gland, as it relates to prostate cancer, is provided on page 3.43.)

The **Cowper's glands** are two pea-sized glands at the base of the penis under the prostate that secrete a clear fluid into the urethra during sexual arousal and before ejaculation. This

fluid, which is sometimes known as **pre-ejaculate**, or “**pre-cum**,” acts as a lubricant for the sperm and coats the urethra while flowing out of the penis.

Erection and Ejaculation

Erection is the process by which the penis fills with blood and becomes firm and erect. It occurs through a complex interaction of mental and/or physical stimulation. Sexual thoughts or feelings may trigger erections, as may either direct stimulation on or near the penis or other types of physical touch on the body. Erection can also occur for reasons other than sexual arousal. Erection occurs naturally during sleep and has even been observed on male fetuses in utero.

The process of **ejaculation** begins when a man reaches a peak level of sexual arousal through stimulation of the penis, known as **ejaculatory inevitability**. At this moment, sperm are released from the epididymides and travel through the vasa deferentia, passing through the seminal vesicles and the prostate, where the sperm mix with the seminal fluid to form semen. Through quick, pleasurable muscular contractions known as an **orgasm**, semen is forcefully expelled through the penis and out of the body. Each ejaculation contains between 3 and 3.5 milliliters of semen, which contain between 200 million and 400 million sperm. Sperm production begins during puberty and continues over the course of the life span. As long as a man remains healthy, he will never stop producing, or “run out of,” sperm, though the number of sperm produced may decline with age.

Before ejaculation, the Cowper’s glands release pre-ejaculatory fluid, which neutralizes the urethra, making the path out of the penis more hospitable to sperm. This pre-ejaculatory fluid does not contain sperm, but could contain bacteria or viruses that could infect a partner. However, if a man becomes aroused again shortly after ejaculation, the new pre-ejaculatory fluid may contain residual sperm that was left in the urethra during the first ejaculation. This may put those who engage in subsequent sexual activity with him at risk for pregnancy and contracting HIV infection and other STIs.

Shortly after ejaculation, blood flows out of the penis and the erection subsides. A man will not be able to achieve another erection for a certain length of time, known as the **refractory period**. This length of time varies by age and may range from a few minutes to many days.

Men may experience erection without orgasm. There is no harm to a man if he engages in sexual activity that does not result in orgasm and ejaculation. Some men may experience a slight pain in the testes or groin if they engage in sexual activity without orgasm, but this pain—which is sometimes referred to as “blue balls”—subsides on its own or can be relieved through masturbation to achieve orgasm. If a man does not ejaculate for a long time, the sperm either are expelled through ejaculations during sleep or are simply reabsorbed by the body.

Nocturnal Emissions

Nocturnal emissions are discharges of semen through the penis during sleep, often as a result of erotic dreams. They are also called **wet dreams** or **night falls**. Wet dreams are natural and cannot harm the individual. They need not and cannot be curbed. They do not require any treatment.

Genital Hygiene

It is very important to keep the genitals clean and healthy, especially for uncircumcised men. Genitals should be washed every day with soap and water. When washing an uncircumcised penis, the foreskin is pulled back and the glans or head thoroughly cleaned. If the glans is not washed regularly, a cheese-like substance called **smegma** is secreted, which may develop into an unpleasant odor (Women's Health Web Site).

Sexual Dysfunction

Male sexual dysfunction is the inability to react emotionally or physically to sexual stimulation in a way expected of the average healthy man or according to a man's own standards of acceptable sexual response.

Erectile Dysfunction (Impotence)

Erectile dysfunction, or **impotence**, occurs when a man is unable to attain or maintain a hard, erect penis satisfactory for sexual intercourse. Traditionally, this has been called **impotence**. Men with erection problems often retain other sexual functions. They may, for example, still have sexual desire, the ability to have orgasms and ejaculate semen.

Erectile dysfunction can occur for a variety of reasons and often may have more than one cause. It can occur for psychological or physical reasons or a combination of both.

Psychological causes of erectile dysfunction include stress and anxiety due to marital, financial, or any other external problem. For example, a man who is having problems in his marriage may find himself unable to have an erection because of the stress and anxiety he is experiencing in his relationship. **Performance anxiety** is also a common cause of erectile dysfunction. Because of anxiety about his ability to "perform," a man finds he cannot perform—which causes more anxiety, thus completing a vicious cycle. Psychiatric illnesses, such as depression, can also cause erectile dysfunction.

The most frequent physical causes of erectile dysfunction are vascular (blood vessel) diseases. Vascular diseases may cause problems involving blood flow into the penis to make it erect. They can also cause problems of holding the blood in the penis to maintain the erection. Thus, hardening of the arteries and other diseases that affect the vascular system are risk factors for erectile dysfunction.

Diseases that affect the nervous system, such as multiple sclerosis and alcoholism, can also cause erectile dysfunction. Some diseases associated with erectile dysfunction, such as diabetes, can affect both the vascular and the nervous systems.

Erectile dysfunction can also result from pelvic fractures or crush injuries experienced in an automobile, motorcycle, or other accident. The accident victim may be left with injured nerves and/or penile arteries that cannot supply enough extra blood to the penis for an erection. Spinal cord injuries that destroy nerve fibers are another cause of erectile dysfunction. Some types of surgery and radiation therapy, such as for treating prostate, bladder, or rectal

cancer, carry a risk for erectile dysfunction. In addition, certain medications might contribute to erectile dysfunction (National Kidney and Urologic Diseases Information Clearinghouse Web Site).

If erectile dysfunction problems occur only occasionally, the problem is probably due to psychological causes, such as stress and fatigue. If the problem is chronic, however, it is important for the client to see a urologist or a physician who can determine the causes through a complete physical examination and a medical history review.

Inhibited Sexual Desire (ISD)

Sexual desire changes over the course of our lives, and occasional loss of desire is not uncommon. In **inhibited sexual desire (ISD)**, however, a persistent loss of desire disrupts a man's sexual relationship(s). It is characterized by diminished sexual attraction, decreased sexual activity, few or no sexual dreams or fantasies, and diminished attention to erotic material. Although ISD is more commonly reported in women than in men, men can be affected by this sexual dysfunction as well.

Similar to erectile dysfunction, the causes of ISD in men can be physical and/or psychological. Physical contributing factors can include testosterone deficiency, whose signs and symptoms are a loss of facial and body hair; a decrease in lean muscle mass; fatigue; lethargy, or a loss of energy; erectile dysfunction; depression; alcoholism; liver or kidney disease; chronic illness; and the side effects of drugs, such as antidepressants, recreational drugs (alcohol, cocaine, marijuana, etc.), and tobacco.

Psychological contributing factors can include stress, relationship problems, sexual trauma, and major life changes.

Usually, decreased desire passes with time, especially if there is open communication between partners. Simple exercises in which partners touch each other without the goal of sex in mind may help to boost libido and reduce stress. If sexual desire does not improve within three months, it may be useful to visit a service provider specializing in sex therapy.

Premature Ejaculation

Premature ejaculation is a condition in men characterized by persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. Premature ejaculation occurs when a man is unable to exert reasonable voluntary control of his ejaculatory response and is unaware of erotic sensations leading to the "point of inevitability" and ejaculation. Premature ejaculation is most common among younger men and men with limited sexual experience. The condition is often associated with performance anxiety.

The causes of premature ejaculation are rarely physical. Some infections of the urethra and prostate, neglected gonorrhea, and overly tight foreskin have been considered as possible physical causes. More commonly, the affected man has not learned to recognize the sensory feedback that indicates ejaculation is imminent. This is common among men who have taught themselves to ignore this sensory feedback and "think of other things" as a means of avoiding ejaculation before they are satisfied or before their partner is satisfied.

The following tips may help men who have concerns about premature ejaculation (Inlander & the People's Medical Society, 1999):

- **Wear a condom.** Using a condom will reduce sensitivity and help to protect against unintended pregnancy and transmission of STIs.
- **Masturbate before sexual intercourse.** Masturbate to orgasm before engaging in sexual intercourse because a second erection lasts longer than a first.
- **Change positions.** Have your partner move to a position that you find less stimulating in order to delay ejaculation.
- **Talk to each other.** Sometimes you need to slow down or stop movement altogether to decrease stimulation. Your partner may not know this fact, so tell him or her.
- **Use the “stop”/“start” technique.** At the brink of orgasm, stop and relax until the ejaculatory feeling subsides. Repeat this exercise several times. This will help you recognize the sensation of ejaculation, thereby allowing more self-control.
- **Use the “squeeze” technique.** At the time of orgasm, gently squeeze (or ask your partner to squeeze) the tip of your penis (or the base of the penis) and hold for several seconds. Repeat the process several times.

Men's Sexual and Reproductive Anatomy and Physiology Myths and Facts

Clients and service providers may believe or want more information about the following statements about men's sexual and reproductive anatomy and physiology. Some of the statements are true, and some are false. Each statement is followed by the term *myth* or *fact*, depending on whether it is false or true, and a brief explanation.

1. It is normal for a man to sometimes be unable to achieve or maintain an erection. (FACT)

Sometimes a man can have difficulty achieving or maintaining an erection. This can result from such conditions as fatigue, illness, and nervousness or can be a side effect of certain medications. This does not necessarily mean that something is physically or emotionally wrong with him. He will most likely be able to achieve and maintain an erection at another time.

2. A man can urinate and ejaculate at the same time. (MYTH)

Although urine and semen are both expelled through the penis, a special muscle controls the flow of urine and semen. The body can expel only one or the other at a time.

3. Morning erections can be the result of waking up from a deep sleep. (FACT)

The penis automatically becomes erect when a man is in a state of deep sleep. This happens regardless of whether or not he is dreaming or having a dream that is sexual in nature. In fact, a man can achieve an erection at many times during the night. Sometimes men wake up in the morning from a dream and have an erection. This has nothing to do with the content of the man's dream or his current sexual desire.

4. A longer penis is more likely to satisfy a woman than a shorter one. (MYTH)

A woman's vagina is most sensitive in the first third of its length. Therefore, many women report that the length of the penis does not affect their sexual stimulation or satisfaction during vaginal penetration.

5. Men are usually capable of holding back their ejaculations as long as they want. (MYTH)

There comes a point during a man's sexual response cycle where he is unable to hold back an ejaculation. This can sometimes be challenging to a couple who are relying on withdrawal as a method of contraception. This does not mean that a man cannot control his sexual desires or urges or that he cannot stop sexual activity once he is sexually aroused.

6. Even as men get older, they still can have erections. (FACT)

It may take longer for an older man to achieve an erection, but most older men can still achieve and maintain erections.

7. Just like women, most men are capable of having multiple orgasms. (MYTH)

Most men can have only one orgasm during an act of sex and must wait through a period of time after ejaculation before they can have another orgasm.

8. Having sex too frequently can be harmful to a man. (MYTH)

As long as a man is protected against STIs, engaging in sex frequently is not harmful.

9. A man can still reproduce into older age. (FACT)

While women stop releasing eggs after menopause, many men produce sperm and can reproduce throughout their entire lives. However, men's hormone levels and the amount of ejaculate they produce might decline as they get older.

10. In men, ejaculation and orgasm are the same process. (MYTH)

In men, orgasm is the muscular contraction of the pelvic muscles right before ejaculation, while ejaculation is the expulsion of semen through the penis. Although these two processes usually occur in tandem, they are indeed separate processes. It is possible for a man to have an orgasm without ejaculating, as well as for a man to ejaculate without having an orgasm.

11. Once a man gets an erection, it is physically harmful to him if he does not ejaculate. (MYTH)

While some men may claim this is true, achieving an erection or engaging in sexual activity without ejaculating is not harmful in any way.

12. A man cannot impregnate a woman while she is menstruating (has her period). (MYTH)

Even when a woman is menstruating, it is possible for her to ovulate (release an egg) and become pregnant. However, a woman is most likely to become pregnant right after ovulation, which usually occurs in the middle of her menstrual cycle—not when she is menstruating.

13. You can tell how long a man's penis is by looking at the size of his hands, feet, or nose. (MYTH)

The size of a man's hands, feet, or nose or any other body part bears no relation to the length of his penis.

14. The penis is a muscle. (MYTH)

Although the penis is sometimes referred to as a muscle, it is more like a "sponge" that fills with blood.

15. A man's penis grows longer with frequent use. (MYTH)

Use has nothing to do with how long a penis might or might not become.

Common Sexual Behaviors

While people may engage in a variety of behaviors for sexual gratification, the following are the most common sexual behaviors—the ones that clients will most commonly discuss with service providers.

Masturbation

Masturbation is the stimulation of the genitals by manual contact—contact with fingers, hands, or objects. To increase sexual arousal, during masturbation individuals may also stimulate their nipples, anus, rectum, or any other part of the body. Masturbation is often an individual's first sexual experience and is performed by people in all cultures around the world. **Mutual masturbation** refers to two partners manually stimulating either each other's genitals or their own genitals in the other's presence. **Group masturbation** refers to the practice of masturbation among several individuals.

Masturbation is a pleasurable activity that can relieve stress, give individuals a sense of well-being, and improve sleep and mood. Masturbation can also help relieve sexual tension at times when a sexual partner is not available, interested, or desired. While many people believe that masturbation results in negative health consequences, no ill effects from masturbation are known.

Self-stimulation involves almost no risk for pregnancy or transmitting and contracting STIs. However, people should avoid contact with parts of the body that have skin lesions, sores, or abnormal discharge because this involves a risk for spreading infections to other parts of the body, such as the eyes or fingers. In addition, if a person touches another person's genitals during mutual or group masturbation, there is a small possibility of:

- Transmitting infections if one partner has another partner's infected secretions or semen on his or her hand and then touches his or her own genitals
- Pregnancy if one partner has semen on his or her hand and then puts his or her hand in a partner's vagina

To maintain general hygiene and cleanliness, individuals should wash their hands before and after masturbating themselves or another person.

Penile-Vaginal Sex

Penile-vaginal sex involves placing a man's erect penis into a woman's vagina and, through friction, stimulating the nerves in the man's penis and in the woman's clitoris and vagina. This activity is commonly known as **sexual intercourse**. However, this text will use the term **penile-vaginal sex** to distinguish this sexual behavior from oral and anal sex, which are also sometimes known as **sexual intercourse**.

Penile-vaginal sex is a pleasurable activity that can relieve sexual tension and stress and give individuals a sense of well-being. Like other sexual activities, it can improve sleep and mood. Because sperm and other body fluids are transferred between partners, having

unprotected penile-vaginal sex can result in pregnancy or, if one partner is infected, the transmission of STIs. To avoid pregnancy, an individual can use an effective contraceptive; to avoid STIs, a person can use a condom.

Oral Sex

The genitals can be stimulated by rubbing, touching, sucking, or licking with the lips, mouth, and tongue. In men, this activity involves stimulating the penis, scrotum, and testes; in women, it involves stimulating the vulva, clitoris, and vagina. This form of stimulation, known as **oral sex**, may also be called **fellatio** when performed on a man and **cunnilingus** when performed on a woman.

Oral sex involves no risk for pregnancy. However, the transmission of STIs is possible because body fluids and infections can be transmitted by contact between the mouth and the genitals.

Anal Sex/Anal, Rectal, and Prostate Stimulation

Anal and rectal skin contain sensitive nerve endings, and some men and women may find anal stimulation with fingers, objects, a penis, lips, a mouth, or a tongue pleasurable. In men, the prostate gland is palpable through the front wall of the rectum within 6 cm (2.4 inches) of the anal opening. Stimulation of the prostate gland through the rectum or by applying firm, external pressure to the tissue between the scrotum and the anus can cause pleasurable sensations.

Anal or rectal contact can transmit STIs. Anal sex is especially risky for the transmission of STIs, such as HIV infection, because inserting and thrusting the penis or other objects into the anus can cause tears and bleeding in the rectum, facilitating transfer of bloodborne germs. Intestinal infections and diarrheal diseases can also be transmitted by anal and rectal contact.

Importance of Mutual Consent during Sexual Activity

When you think about common sexual behaviors and their health implications, it is important to understand that mutual consent is the basis for discussion of healthy sexual activity or relationships. For any sexual behavior, it is assumed that both of the partners are consenting, with neither person being forced or coerced to engage in the behavior. Sexual assault, rape, forced prostitution, coerced sexual activity, and forced sex in marriage are worldwide problems. In most cultures, any sexual activity with children, even if voluntary on the part of the children, is viewed as coercive and is referred to as **child sexual abuse**.

The psychological consequences of forced or coerced sexual activity can cause lifelong damage, even if no long-lasting health consequences result. Men are more often the perpetrators in these situations, and women are more often the survivors. However, it is important to recognize that men—and particularly boys—can also be survivors of forced and coerced sexual activity. Being the victim of past childhood sexual abuse is common among sex offenders.

Health Considerations of Sexual Behaviors

Service providers must be aware of the range of ways that clients may perceive themselves as sexual and gendered beings—and, consequently, the health implications of any sexual behaviors that clients may engage in. This is important to ensure that all clients receive appropriate health services.

Although a variety of sexually arousing behaviors may be enjoyable, engaging in some of them can have serious health consequences. Service providers need to be able to distinguish those behaviors that put individuals at risk for transmitting and contracting STIs or are potentially harmful in other ways from those that are harmless. This will enable service providers to advise clients who engage in those behaviors about the risks involved. Even if your job does not involve direct client counseling, knowing more about the health consequences of sexual behaviors may help you be more understanding and supportive of clients and the staff who work with them.

Safer Sex: Protecting against STIs

Some sexual behaviors carry a high risk for transmitting and contracting STIs, while others carry little or no risk.

A person can reduce his or her risk for sexual transmission of STIs three ways:

1. Abstaining from sex
2. Engaging in sexual relationships only with partners whom he or she is sure are not infected with an STI
3. Practicing “safer sex”

Since this text does not cover all sexual behaviors, it is important to understand the concepts of safer sex so that you will be better able to determine whether an unfamiliar sexual behavior is physically harmless or dangerous to your client. Any unprotected sexual contact with an infected partner that causes bleeding or involves contact with semen, vaginal fluids, lesions, or sores on the body can transmit STIs. Understanding which sexual behaviors are common in the communities you serve will help you explain to individuals who engage in those behaviors ways to reduce their risk. Equally important, however, is providing reassurance to clients who express concern about behaviors that are harmless.

Additional information on STI transmission and common STIs is provided later in this chapter on page 3.32.

Other Health Consequences of Sexual Behaviors

Certain behaviors used to enhance the sexual experience may be potentially harmful or dangerous in ways other than increasing the risk for transmitting and contracting STIs.

Sexual behaviors that may be harmful include:

- **Placing objects in the rectum.** This may be harmful, depending on the objects and how they are used. Objects should be clean, unbreakable, and manipulated gently, and have no sharp edges. In addition, the objects should not be inserted too deep or left in

for extended periods of time, and they should not be shared with others unless first disinfected or covered with a new condom.

- **Placing objects in the vagina.** This is generally harmless if the objects are clean, unbreakable, manipulated gently, and have no sharp edges. In addition, the objects should not be left in for extended periods of time, and they should not be shared with others or inserted in the vagina after being inserted in the rectum unless first disinfected or covered with a new condom.
- **Using devices to constrict and prevent blood flow out of the penis.** This can enhance sexual pleasure and maintain a longer erection. A ring or any other object that may be difficult to remove—such as a cord, string, or ordinary rubber band—should never be used on the penis. The constriction may make it impossible for blood to flow out of the penis after an orgasm, possibly causing irreversible tissue damage. A band with a snap or Velcro release tape is a safer alternative.
- **“Dry sex.”** This behavior—which involves putting twigs, herbs, dirt, tree bark, detergents, or other substances in the vagina or taking other measures to dry out the vagina in order to cause friction—is painful and harmful to both women and men. Dry sex can increase the chances of causing tears, scrapes, or other damage to the vagina and penis. This behavior also suppresses the natural bacteria present in the vagina, thereby increasing the risk for transmitting and contracting HIV infection or other STIs. It is also believed, though not proven, that the extra friction may cause condoms to tear more easily, increasing the woman’s chances of becoming pregnant and both partners’ chances of transmitting and contracting STIs.
- **Partially suffocating yourself or someone else before or during orgasm.** This can be very dangerous, possibly leading to accidental injury or death, especially if communication between the partners fails.

Discussing Sexual Orientation during Counseling Sessions

Service providers must create a safe and confidential atmosphere at the health care facility to help ensure that all clients can discuss their sexual behaviors openly without fear of criticism, punishment, or disclosure. This is especially important because many sexual behaviors can put clients at risk for transmitting and contracting HIV infection and other STIs. But this may be difficult for many service providers to achieve, especially when they have strong views about sexual behaviors that may differ from their own, as well as the individuals who engage in them. Therefore, understanding your values and feelings about individuals who engage in various sexual behaviors is the first step toward being able to provide all clients with appropriate health care services.

Same-Sex Sexual Activity

Feelings of sexual attraction emerge in childhood. In cultures where attraction to members of one’s own sex is considered socially unacceptable, a young person who has such feelings may hide or suppress them. Some individuals may continue to hide or suppress these feelings throughout their lives and may marry and have children with a person of the op-

posite sex. They may—or may not—ever act on their feelings and engage in sexual activity with members of their own sex.

Attitudes toward different sexual behaviors, and how sexual orientation is defined, can vary across or within cultures. Not all individuals who have had one or more sexual contacts with members of their own sex define themselves as homosexual or are considered homosexual by society. For example, some adolescent boys who experiment sexually with other boys (for example, masturbating in a group) and some men who have sex with other men in isolated settings, such as prisons, do not consider themselves and are not considered homosexual. In addition, individuals who engage in same-sex sexual activity may not be exclusively attracted to members of their own sex and may not wish to engage in sex only with members of their own sex. Indeed, some married persons engage in same-sex sexual activity outside of marriage and still consider themselves heterosexual. Persons who have sex with both men and women may consider themselves to be bisexual, homosexual, or heterosexual.

With few exceptions, sexual attraction and sexual activity between individuals of the same sex are opposed by most cultures and are often the source of fear, hatred, and misunderstanding. As a result, many individuals who engage in same-sex sexual activity—whether regularly, on occasion, or just one time—may not fully disclose these behaviors to a service provider.

Focus on Sexual Behaviors, Not Sexual Orientation

When addressing a client's concerns, giving a client health education or information, or providing services, service providers must focus on the client's sexual behaviors, not the client's sexual orientation. This is because it is the behaviors—not the orientation—that put individuals at risk for transmitting and contracting HIV infection and other STIs.

It is also important to refrain from making assumptions about an individual's behaviors or lifestyle based on stereotypes. Homosexual, bisexual, and heterosexual individuals may abstain from sex, may build loving and lasting relationships with one partner, and may have multiple partners and/or engage in a variety of sexual behaviors or risky sexual activity.

Sexuality Myths and Facts

Clients and service providers may believe or want more information about the following statements about sexuality. Some of the statements are true, and some are false. Each statement is followed by the term *myth* or *fact*, depending on whether it is false or true, and a brief explanation.

1. A man's nipples are sensitive to sexual arousal. (FACT)

Although men's breasts and nipples are not often considered sexual, they are, in fact, sensitive to touch and sexual arousal. There is variation in nipple sensitivity among men, and nipple stimulation may or may not be perceived as enjoyable by a particular individual.

2. A man who has had sex with another man is a homosexual. (MYTH)

Having a same-sex sexual experience does not mean a person is homosexual. Many people have sex with members of their own sex as a way of exploring their sexuality. What determines whether or not a man is homosexual are his feelings, not his sexual behaviors. Homosexual men feel primarily attracted to other men. Therefore, even if a man does engage in sexual activity with another man, that does not necessarily make him a homosexual or mean that he is necessarily or exclusively attracted to other men.

3. A man can sexually assault his wife. (FACT)

Any time a man engages in sexual contact with his wife without her consent should be considered a sexual assault.

4. Having sex too frequently can be harmful to a man. (MYTH)

As long as a man is protected against STIs, engaging in sex frequently is not harmful.

5. Only men masturbate. (MYTH)

Both men and women masturbate.

6. Masturbation is harmless. (FACT)

Masturbation does not cause harm to anyone of any age, unless an object is inserted into the vagina or anus in a harmful way.

7. A man's sex drive (need to have sex) is stronger than a woman's. (MYTH)

Although it is often believed that men have a stronger sex drive than women, this is not the case. Sex drive varies from person to person, and both men and women can experience different levels of sex drive at different times.

8. Men need to have sex in order to maintain good health. (MYTH)

It is normal and healthy for both men and women to have sexual feelings and a desire to express them, but neither men nor women need to have sex in order to be healthy.

9. Alcohol makes it easier for men to become aroused. (MYTH)

Actually, alcohol has the opposite effect. Alcohol is a depressant. It decreases the flow of blood to the genital area, making it more difficult to have an erection and experience orgasm.

10. In a same-sex sexual relationship, one person usually takes the male role and the other takes the female role. (MYTH)

In a same-sex sexual relationship, just as in an opposite-sex sexual relationship, both partners have the freedom to choose their gender roles and the roles they may play during sexual activity. There is no need for one person to always take the male role and the other to always take the female role.

Common Client Concerns

Sometimes men may pose challenging questions about their anatomy or physiology to a service provider. Here are some suggestions on how to address these concerns:

Sample phrases to use when beginning to answer men's questions about anatomy and physiology include:

- "That is a really good question. . . ."
- "You know, many men have asked that question before. . . ."

- “You may already know this, but. . . .”
- “Many men are concerned about the same thing. . . .”
- “I can understand why you would be concerned about this. . . .”
- “I am glad you asked this. . . .”
- “You are really brave to ask this. . . .”
- “It is great that you came here/called to get more information. . . .”

If you are not sure about how to answer a question, you can follow up by saying something like:

- “There are people here who can give you more information about this. . . .”
- “I can help you get more information about this. . . .”
- “There is someone here who you can talk to about this. . . .”

If you know the answer to a question, you may want to begin with one of the introductory phrases and then follow up with some information. Next, you may want to make the appropriate referral for more information—whether that means providing a brochure, giving a referral to another facility, or simply taking down some information for an appointment at your facility.

When responding to clients:

- Listen carefully, and give the client time to relate his problem at his own pace. Interrupting him may distract him and make it more difficult for him to describe his issue. If you need additional information, ask your questions after he has finished talking.
- Do not express surprise, shock, or any sign of judgment. A calm and professional demeanor may give the client confidence in your ability to help him.
- Keep information your clients give you confidential. Few things disturb clients more than hearing service providers or other staff gossiping about other cases. Necessary clinical discussions should be done out of earshot of other clients as much as possible to ensure privacy.

Sample Responses to Common Client Concerns about Anatomy and Physiology

1. **Concern:** “Is my penis big enough?”

Possible response: “Many men are concerned about the size of their penis. Some men wonder if their penis is as big as other men’s. While penises may vary in size when they are flaccid or not erect, most men’s penises are close in size when they are erect. However, if you are concerned about the size of your penis, I will be able to determine whether it is abnormally small.”

2. **Concern:** “Why does one of my testes hang lower than the other?”

Possible response: “It is perfectly normal for one testicle to hang lower than the other and for each of the testes to have a slightly different size or shape.”

3. **Concern:** “I could not get an erection the last time I had sex.”

Possible response: “Most men experience that at some point in their life. This may have happened to you for a variety of different reasons. It could simply have been stress or anxiety about a sexual encounter, or it could have been a sign of a physiological cause. The good news is that I can help you.”

4. Concern: “I wish I could last longer when I have sex.”

Possible response: “Many men wish for the same thing. Any ejaculation that happens before you want it to may be due to overeagerness or ‘performance anxiety.’ You can do several things to last longer, if you wish, including wearing a condom to reduce sensitivity. Would you like me to tell you more about this?”

5. Concern: “My penis looks different than other men’s penises.”

Possible response: “Some penises look different from others because some men are circumcised and some men are not. Some men’s penises look very different when they are flaccid or not erect. The width and length of a flaccid penis may vary, but the look and size of a man’s penis have nothing to do with how much of a man or how good a lover or sexual performer he is. However, if you are concerned about the appearance of your penis, I will be able to determine whether there is anything abnormal about it.”

6. Concern: “Is there something wrong with me if I wake up with an erection?”

Possible response: “Many men wake up with erections. Every night while a man sleeps, he may get four or five erections in his sleep. Sometimes he may wake up with an erection, regardless of whether he was having a sexual dream or sexual thoughts upon awakening.”

7. Concern: “Is there something wrong with me if I ejaculate in my sleep?”

Possible response: “There is nothing wrong with you. It is perfectly normal to ejaculate while you sleep. Sometimes such ejaculations are called nocturnal emissions, or ‘wet dreams.’ They are not harmful in any way, and many men may not even realize they have had one.”

8. Concern: “If I have sex too much, will I run out of sperm?”

Possible response: “No, men do not run out of sperm, regardless of how many times they have sex. Men are always producing sperm. While the amount of sperm produced may decrease as a man gets older, a healthy man will continue to produce sperm that is capable of resulting in pregnancy into older age.”

9. Concern: “I am afraid I might urinate inside my partner during sex.”

Possible response: “A lot of men wonder about that. Fortunately, a small muscle inside the prostate gland prevents urine from coming out of the bladder during sexual activity. Would you like me to explain more about that to you?”

10. Concern: “Sometimes I have sex and cannot achieve an orgasm. Is something wrong with me?”

Possible response: “That sounds frustrating. Other men have raised concerns about the same thing. Would you like to talk more to me about this?”

Contraception

Contraception is the prevention of pregnancy. Broadly speaking, any behavior, technique, drug, or medical device that achieves this end can be defined as a contraceptive method.

Types of Methods

A wide variety of contraceptive methods are available. Some contraceptive methods are temporary, which means that they are designed to space or delay a pregnancy, while others

are permanent, which means that they are designed to irreversibly prevent pregnancy. Vasectomy and female sterilization (tubal ligation) are permanent methods; all other methods are temporary.

Regardless of whether the method is one in which the male partner participates most actively in its use (such as the condom) or whether the female partner participates most actively in its use (such as the intrauterine device, or IUD), men can play an important role in the method's use and effectiveness. This section focuses on methods in which men participate most actively—the condom, vasectomy, and withdrawal—as well as fertility-awareness methods, which require both partners' active participation.

How Contraceptives Work

Contraceptive methods work in a variety of ways. In simple terms, five events must happen for a normal pregnancy to occur:

1. Sperm must enter the vagina.
2. The sperm must travel through the cervix and uterus and enter the fallopian tubes.
3. An egg must be present in the fallopian tubes within 48 hours of the introduction of sperm.
4. The sperm must fertilize the egg.
5. The fertilized egg must implant into the lining of the uterus.

All methods of contraception are designed to prevent one or more of these five events from occurring.

To reduce the risk for STIs, couples often combine the use of condoms along with another contraceptive method.

Condoms

A **condom** is a thin sheath that is placed over the penis just before sexual activity. It acts as a barrier, preventing pregnancy by keeping semen from entering the vagina. Condoms also prevent contact with semen and other secretions that transmit STIs; thus, they are used to protect against STIs.

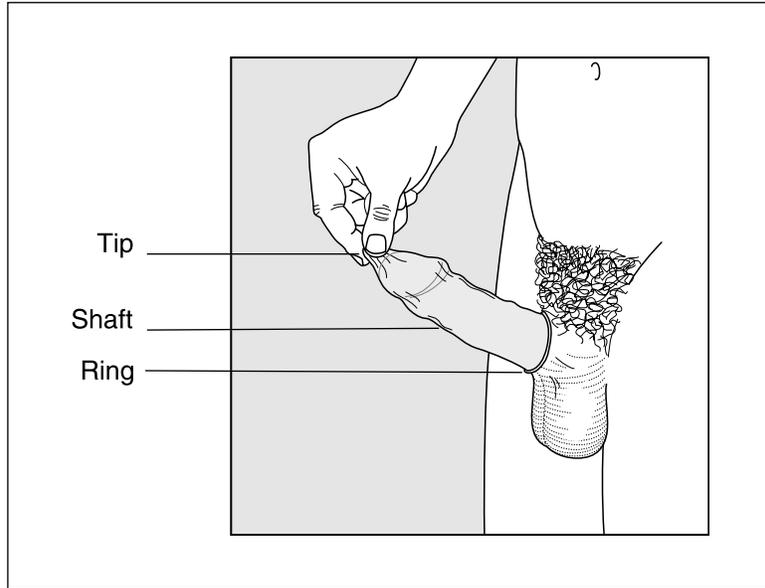
Typical Features of Condoms

Though condoms vary in length, diameter, shape, contour, texture, color, flavor, and fragrance, they share some basic characteristics. As shown in Figure 3-4 on page 3.22, all condoms consist of:

- A **tip**, which provides a reservoir for semen, reducing the chance that the condom will break during ejaculation
- A **shaft**, which covers the penis and provides the barrier
- A **ring** at the base, which helps hold the condom in place

Many condoms are lubricated with either a silicone or a water-soluble, jelly-like lubricant. Some condoms have a spermicide, nonoxynol-9, in the lubricant, which may help make the condoms more effective in preventing pregnancy and reducing disease transmission. However, people who are allergic to this spermicide should not use condoms that contain it.

Figure 3-4. Typical Features of Condoms



Condom Material

Condoms may be made of latex, natural rubber, polyurethane, or lambskin. While all condoms prevent the passage of sperm, latex and polyurethane condoms also prevent the transmission of STIs. Lambskin condoms are not recommended for protection against STIs because their small pores (openings) can permit passage of some viruses, such as hepatitis B, herpes, and HIV infection.

Latex condoms are used most commonly because they are inexpensive, are widely available, and prevent the transmission of STIs. However, some individuals are allergic to latex. If one or both members of a couple are allergic to latex, the couple should use a polyurethane condom, if available, to prevent the transmission of STIs.

Effectiveness

With typical use, condoms have an 86% effectiveness rate. This means that of 100 couples who use condoms for one year, 14 couples will experience an unintended pregnancy.

Advantages and Disadvantages

Advantages	Disadvantages
<ul style="list-style-type: none"> • Protect against pregnancy and STIs • Are widely available and low-cost • Help maintain an erection longer and prevent premature ejaculation 	<ul style="list-style-type: none"> • Reduce sensitivity • Can break • Occasionally interfere with achieving or maintaining an erection • Can cause a loss of spontaneity

Condom Instructions

All clients considering the use of condoms should be provided with instructions and practice on their correct use (see Figure 3-5 on page 3.24). Although service providers often mistakenly assume that all men know how to correctly use condoms, incorrect use is common and is a major cause of condom failure. Consequently, it is important for you to have experience demonstrating the use of condoms so that you can effectively explain their use to clients.

Tips for Clients on Effective Use of Condoms

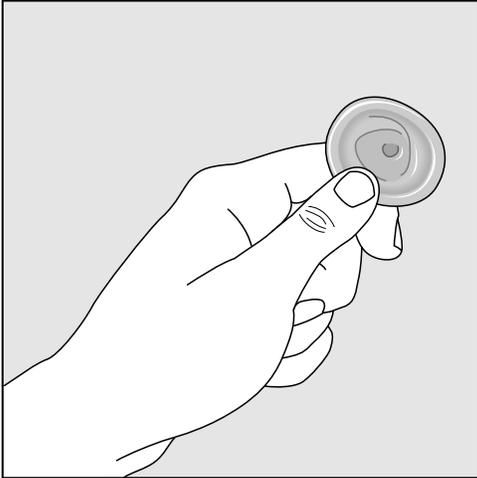
- Put on the condom before your penis comes in contact with your partner. This will reduce the risk for transmitting and contracting STIs.
- Use a condom only once; do not wash or reuse it.
- Always store condoms in a cool, dry place, and use them before the expiration date on the package.
- Do not use a condom if:
 - The package is broken
 - The condom is brittle or dried out
 - The color is uneven or has changed
 - The condom is unusually sticky
- If the condom tears or slips during sex, stop and replace it before continuing.
- If, after ejaculation, you realize that the condom has broken or slipped off, immediately wash your penis with soap and water to minimize the risk for infection. If the condom is being used for contraception, immediately inform your partner, tell your partner to insert a spermicidal foam or gel in her vagina, and discuss with her the use of emergency contraception to reduce the risk for pregnancy.
- Condoms may be used for contraception and/or protection against STIs. When using a condom to protect against STIs, wear either a lubricated or an unlubricated condom, as follows:
 - For penile-vaginal sex, you can use either a lubricated or unlubricated condom.
 - For oral sex, unlubricated condoms are generally preferred.
 - For anal sex, lubricated condoms are best because the anus does not have natural lubrication of its own.
- Do **not** use grease, oils, lotions, petroleum jelly (Vaseline), or other oil-based lubricants to make the condom slippery. These substances can cause the condom to break—a common reason for condom failure. Use only creams, gels, and foams that do not have oil in them. Since vaginal medications are commonly oil-based, do not use a condom if your partner is using a vaginal cream medication. The chart on page 3.25 shows lubricants that are safe and unsafe for use with condoms.

Withdrawal

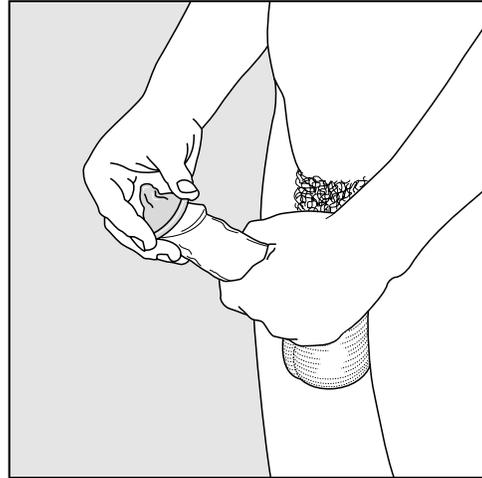
Withdrawal is a method in which the man takes his penis out of his partner's vagina just before he ejaculates. This method prevents pregnancy by keeping sperm from entering the vagina. While some fluid does leak from the penis before ejaculation, this pre-ejaculatory fluid usually contains no sperm. (It may, however, contain some sperm from a recent, previous ejaculation, which can lead to fertilization.) However, the pre-ejaculate can contain bacteria and viruses that cause STIs.

Figure 3-5. Instructions for Condom Use

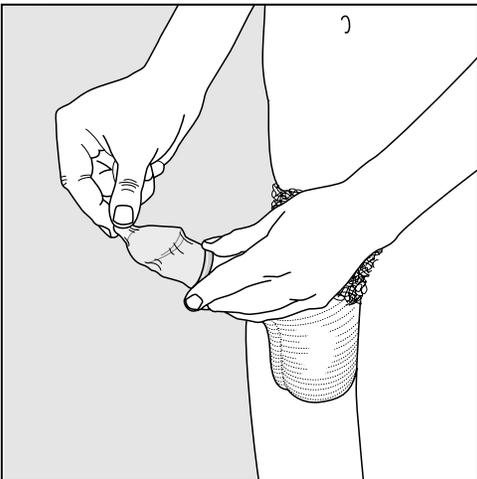
Before intercourse:



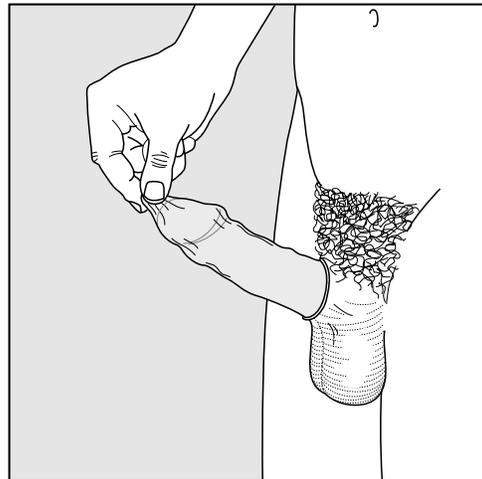
1. Carefully open the package so the condom does not tear. (Do not use teeth or a sharp object to open the package.) Do not unroll the condom before putting it on.



2. If you are not circumcised, pull back the foreskin. Put the condom on the end of the hard penis.
Note: If the condom is initially placed on the penis backwards, do not turn it around. Throw it away and start with a new one.



3. Pinching the tip of the condom to squeeze out the air, roll on the condom until it reaches the base of the penis.

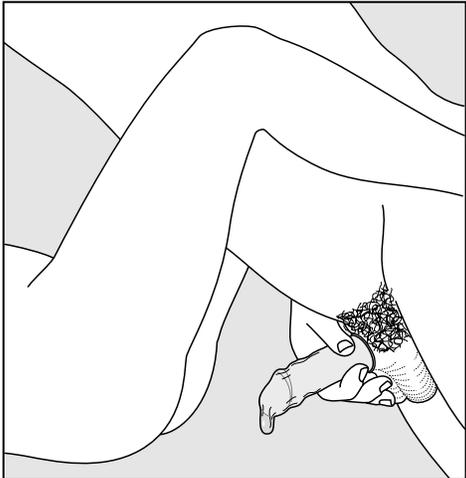


4. Check to make sure there is space at the tip and that the condom is not broken. With the condom on, insert the penis for intercourse.

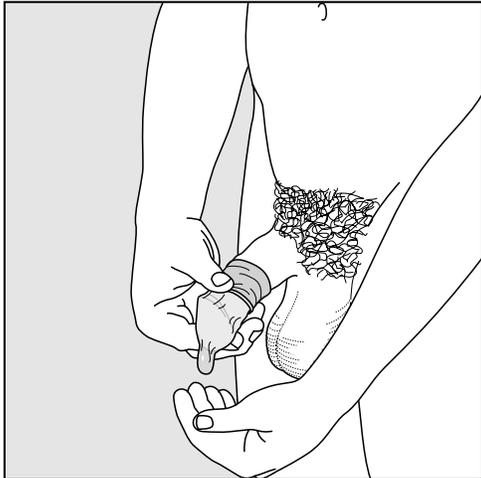
(continued)

Figure 3-5. Instructions for Condom Use (continued)

After intercourse:



1. After ejaculation, hold onto the condom at the base of the penis. Keeping the condom on, pull the penis out before it gets soft.



2. Slide the condom off without spilling the liquid (semen) inside. Dispose of the used condom.

Lubricants That Are Safe and Unsafe for Use with Condoms

Safe for Use with Condoms	Not Safe for Use with Condoms
<ul style="list-style-type: none"> • Contraceptive foams, creams, and jellies • Egg whites • Water • Saliva • Glycerin • Silicone-based lubricants • Water-based lubricants 	<ul style="list-style-type: none"> • Baby oils • Massage oils • Hand or body lotions • Cooking oils: coconut, olive, peanut, corn, sunflower, butter, margarine • Fish oils • Hemorrhoid ointments • Insect repellents • Vaginal cream medications • Palm oil • Suntan oil • Petroleum jelly (Vaseline) • Mineral oil • Burn ointments

Source: Adapted from *Contraceptive Technology*, 17th revised ed., 1998.

Note: Many of the materials listed in this chart are not used intentionally as lubricants. However, clients should be aware of circumstances in which a condom might be accidentally exposed to one or more of them. For example, if a man has suntan lotion on his hands and then puts on a condom, he may expose the condom to the oils in the lotion, which can then degrade the condom and make it unsafe for contraception or protection against STIs. Similarly, if a woman is using an oil-based cream and the condom touches it before sex, the condom could become damaged.

Effective Use of Withdrawal

Withdrawal may not be a good method for men who have difficulty predicting when they will ejaculate or who tend to have repeat orgasms. In general, this contraceptive method is more effective for couples who are familiar with each other's sexual responses than for new sexual partners.

To practice withdrawal effectively:

- Before penile-vaginal sex, urinate (to clean any sperm from a previous ejaculation) and wipe the tip of your penis.
- When you feel you are about to ejaculate, remove your penis from your partner's vagina. Ejaculate away from the entrance to her vagina.

Sometimes when a couple is practicing withdrawal, the man will not be able to withdraw his penis in time and will ejaculate inside his partner. When this occurs, the male partner has an important responsibility to inform his partner that he ejaculated inside her because a woman may not always be able to tell whether she has semen inside her vagina.

If a man ejaculates into his partner's vagina before withdrawal, she can reduce her risk for pregnancy by:

- Immediately inserting a spermicide into her vagina, *and/or*
- Using emergency contraception within 72 hours. (Information about emergency contraception is provided on page 3.32.)

Effectiveness

Withdrawal is highly effective when used properly during every act of penile-vaginal sex. However, with typical use, withdrawal has an 81% effectiveness rate. This means that of 100 couples who use withdrawal for one year, 19 couples will experience an unintended pregnancy.

Advantages and Disadvantages

Advantages	Disadvantages
<ul style="list-style-type: none">• No cost• No devices required• Is always available• Does not require a visit to a health care provider• Better than no method at all	<ul style="list-style-type: none">• May interrupt the sexual pleasure of both partners• Requires a high level of self-control and may increase anxiety in both partners before impending ejaculation• Does not protect against STIs• May be difficult to accomplish in certain positions• May require a level of comfort for the man to communicate with his partner that he is about to ejaculate

Vasectomy

Vasectomy is a male sterilization procedure that prevents the passage of sperm into the ejaculate by blocking the spermatic cords (vasa deferentia) (see Figure 3-3). Vasectomy is simpler, safer, and less expensive than female sterilization. Vasectomy is a minor surgical procedure that can usually be done in a doctor's office or at a clinic and usually takes no more than 30 minutes.

Two basic approaches for scrotal entry are available: conventional vasectomy and no-scalpel vasectomy (NSV).

Conventional Vasectomy

In conventional vasectomy, also called **incisional vasectomy**, the service provider uses a scalpel to make one midline incision or two incisions in the scrotal skin. The incision(s) is usually 1 to 2 cm long and is routinely closed with sutures after the vasectomy has been completed. Usually, only the area around the skin-entry site is anesthetized.

NSV

NSV was developed and first performed in China in 1974 by Dr. Li Shunqiang and has since gained acceptance worldwide. This technique uses a vasal-nerve block and two specialized instruments—a ringed clamp and dissecting forceps—to isolate and deliver the vas. The vasal-nerve block provides better anesthesia than does simply anesthetizing the skin around the entry point. And because the scrotal-skin puncture made with the dissecting forceps is so small, sutures are not needed.

Once the vas is brought into the open using either conventional vasectomy or NSV, it can be occluded using a variety of methods. These include ligation with sutures, cautery, application of clips, excision of a segment of vas, fascial interposition, or some combination of these.

Advantages of NSV over Conventional Vasectomy

NSV offers several advantages over conventional vasectomy:

- Reduced risk for bleeding and other surgical complications
- Reduced swelling at the injection and puncture sites
- Reduced time required for the procedure
- Less damage to the tissue
- Less pain during the procedure and the early follow-up period
- No need for stitches
- Does not require a return visit to remove the stitches
- May decrease men's fear of vasectomy since no scalpel or stitches are used

After a vasectomy, a man can still achieve erections and orgasms. The amount of fluid in his ejaculations is not different, and the fluid looks and smells the same. A man's hormones, beard, and voice do not change, nor does his sex drive or ability to have sex. The only difference is that the man has no sperm in his semen, so he cannot make a woman pregnant.

Complications

Like all surgery, vasectomy involves some risk, but the chance of serious problems is small. Common complaints after surgery are swelling of the scrotum, bruising, and pain. A scro-

tal support, mild pain medication, and local application of ice are usually sufficient treatment. The most common complications of vasectomy are infection, inflammation, and blood clots in the area of the incision. However, these problems do not happen often and usually disappear with simple treatment.

Effectiveness

The contraceptive effects of vasectomy are not immediate because viable sperm must be cleared from the vas. Thus, the vasectomy user and his partner(s) must practice alternative methods of contraception for some time after the procedure. Overall, vasectomy is highly effective and is one of the most reliable contraceptive methods available. Failure rates are commonly quoted as less than 1%.

Vasectomy failure may be due to user failure or to failure of the technique itself. A vasectomy can fail if the tubes were not completely sealed off during surgery. Sometimes, the cut ends of the tubes join together by themselves, or an opening develops that lets sperm pass through. A pregnancy may also occur if a couple does not use some other type of contraception for at least 12 weeks after the procedure before having unprotected penile-vaginal sex, or until a test of the semen shows that the man is sterile.

Because vasectomy is intended to be a permanent procedure, the client should be counseled and well informed before making a decision.

Advantages and Disadvantages

Advantages	Disadvantages
<ul style="list-style-type: none"> • Highly effective • Relatively inexpensive (when considered over time) • Permanent • Very little time required for the procedure • Client is able to return to work quickly 	<ul style="list-style-type: none"> • Risks associated with a surgical procedure • Expensive in the short term • Reversal of the procedure is expensive and fertility cannot be guaranteed • Not available everywhere • Not effective immediately

Fertility-Awareness Methods

Most women have an egg available for fertilization only a few days out of their monthly menstrual cycle. Therefore, there is a time each month when a woman can get pregnant and a time when she cannot get pregnant. **Fertility-awareness methods** are designed to help couples identify the days of the month when the female partner is most likely to get pregnant so that they can avoid penile-vaginal sex on those days.

Couples can use a number of different strategies (and combinations of them) to determine when the female partner can get pregnant—that is, when she is likely to have an egg ready to be fertilized. The most common strategies are as follows.

Calendar (Rhythm) Method

This method is based on the typical length of a woman’s menstrual cycle. Women whose periods occur on a regular schedule can estimate the day of the month when they will ovulate and can avoid penile-vaginal sex for several days before and after that day.

Basal Body Temperature Method (BBT)

This method is used to identify the small rise in body temperature that typically occurs with ovulation. However, because it indicates when ovulation has already occurred, it is difficult to determine the beginning of the fertile period. The safest way to use BBT is to avoid penile-vaginal sex or use a barrier method during at least the first half of the cycle until three days after the BBT has risen.

Cervical Mucus Method

Over the course of a woman’s menstrual cycle, the color, consistency, and amount of her cervical mucus change. These changes are a normal part of a woman’s cycle. Being “wet” does not necessarily mean that a woman has been sexually active. To avoid pregnancy using this method, a woman should not have penile-vaginal sex:

- On any day that she can feel or see mucus on her fingers, toilet tissue, or underpants
- If she is unsure about whether there is mucus
- Until the fourth day after the “peak symptom day,” the last day of the wettest mucus
- During her menstrual period

Effectiveness

While each fertility-awareness method is highly effective when used correctly and consistently with every sex act, the average typical-use effectiveness rate of all types of fertility-awareness methods is 20%. This means that of 100 couples who use a fertility-awareness method for one year, 80 couples will experience an unintended pregnancy. Couples can combine fertility-awareness methods to more accurately predict the time of ovulation.

Note: If the female partner is not free to refuse sexual activity, fertility-awareness methods are probably not appropriate for the couple.

Advantages and Disadvantages

Advantages	Disadvantages
<ul style="list-style-type: none">• Low- or no cost• Always available• Are permitted by some religions and cultures that do not permit other methods of contraception• Do not cause a loss of spontaneity after sexual activity has begun	<ul style="list-style-type: none">• Require planning and discipline• Do not protect against STIs, including HIV infection• Take time to learn• Couple may find it hard to know when the safe time is• Couple cannot have penile-vaginal sex, or must use another contraceptive method, during the female partner’s fertile times

Men's Role in Contraception

Ideally, contraception is the joint responsibility of a male and a female partner, and the method they choose should reflect the needs and concerns of both partners. Yet, even when this is the case, the primary responsibility for actually using the contraceptive method often falls on one of the partners. When using a male method, such as condoms, withdrawal, or vasectomy, the male partner has the primary responsibility. But even when the couple uses a female method, such as oral contraceptives or Norplant implants, the male partner can play an important role in its use and effectiveness.

Ways That Men Can Support Contraceptive Use

In general, men's role in using female methods is providing support. Men can give their partners:

- Financial support (e.g., by helping them pay for the method)
- Emotional support (e.g., by accompanying them to the facility, discussing the reasons for choosing one method over another, and/or supporting their choice of method)
- Help with the method if they desire (e.g., by helping to insert the spermicide, if needed, or reminding them when to use it)
- Support by using an alternative method (such as withdrawal or condoms) in case they forget to use, have an unexpected problem with, or wish to discontinue their chosen method

Ways That Men Can Hinder Contraceptive Use

Unfortunately, men can also hinder women in using female methods of contraception. In addition to withholding the type of support described above, male partners may actively interfere with their partner's choice of method. For example, they may:

- Forbid her from using any method, thereby forcing her to use one secretly if she chooses
- Not allow her the time to use the method before penile-vaginal sex (e.g., inserting a spermicide, or preparing and inserting a diaphragm, female condom, or cervical cap)
- Complain or criticize her for the inconvenience of her method of choice (e.g., female condom)
- Pressure her to use a method that may be harmful to her health
- Pressure her to have penile-vaginal sex during her fertile periods (e.g., when using a fertility-awareness method)

Men should be encouraged to be full partners in a couple's reproductive life. One way to do so is to have respect for their partners and their partners' contraceptive choices. In all cases, men should consider which method is most beneficial for both their partners and themselves.

Contraception Myths and Facts

Clients and service providers may believe or want more information about the following statements about contraception. Some of the statements are true and some are false. Each statement is followed by the term *myth* or *fact*, depending on whether it is false or true, and a brief explanation.

1. A man does not need to use contraception after a certain age because eventually he loses the ability to reproduce. (MYTH)

While women stop producing eggs after menopause, many men continue to produce sperm throughout their lives.

2. A man cannot impregnate a woman while she is menstruating. (MYTH)

Even when a woman is menstruating, it is possible for her to ovulate (release an egg) and become pregnant. However, a woman is most likely to become pregnant right after ovulation, which usually occurs in the middle of her menstrual cycle, when she is not menstruating.

3. Anal sex is a risk-free way for women to avoid pregnancy. (MYTH)

Anal sex holds risks for both STI transmission and pregnancy. Anal sex is one of the easiest ways to spread HIV infection and some other STIs, and a woman can become pregnant from anal sex if semen from the man's ejaculation seeps out of her anus and enters the opening of her vagina.

4. Abstaining from sex is the only method of contraception that is 100% effective. (FACT)

Avoiding penile-vaginal sex and avoiding any genital or anal contact with semen are the only ways to absolutely avoid pregnancy.

5. The best way to use a condom is to pull it on tight. (MYTH)

The best way to use a condom is to leave some space at the tip to hold the semen after ejaculation. Some condoms have reservoir tips for this purpose; however, even if such a tip exists, some space should be left when putting on the condom.

6. Condoms, when used consistently and correctly, provide effective protection against pregnancy. (FACT)

Condoms provide very good protection against pregnancy when used correctly. However, many people use condoms incorrectly, thereby causing a typical-use effectiveness rate of 86%.

7. A woman is protected against pregnancy the day she begins taking the pill. (MYTH)

Most doctors recommend that women either abstain from penile-vaginal sex or use another method of contraception for seven days after a woman begins using the pill. After this time, the woman is protected from pregnancy every day, including during her period.

8. Condoms are an effective means of contraception because they do not break easily or leak. (FACT)

Condoms are very effective, depending on how carefully they are used. They are inspected before being sold, and safety regulations require that condoms be able to hold a large amount of air without breaking. Condoms should not be exposed to heat or oil-based lubricants because both can cause the rubber to deteriorate. This, in turn, can increase a condom's chances of breaking.

9. Aside from abstinence, male and female condoms are the only contraceptive methods that can protect against STIs. (FACT)

Male and female condoms made of latex or polyurethane are the only contraceptive methods that protect against all STIs; no other methods offer such protection. Lamb-

skin condoms do not protect against all STIs. A couple should always use condoms made of latex or polyurethane during sex if the partners are at risk for STIs.

10. There is a birth control pill that men can take to prevent pregnancy. (MYTH)

Scientists are currently developing a hormonal method of contraception for men that may be taken in the form of an injection or pill. However, the method is not currently available.

11. Vasectomy involves removing a man’s testes so that he can no longer produce sperm. (MYTH)

Vasectomy is a simple operation that clips the vasa deferentia so that sperm cannot pass from the testes to the urethra. The testes remain completely intact after vasectomy.

12. Vasectomy is a simpler operation than female sterilization (tubal ligation). (FACT)

Vasectomy is a much simpler and shorter procedure than any female sterilization procedure. A vasectomy also requires much less recovery time than a female sterilization.

13. A woman can take emergency contraception pills to reduce the risk of pregnancy after having unprotected sex. (FACT)

Emergency contraception is an effective mechanism for reducing the risk of pregnancy when contraception fails or is not used. Emergency contraception should be used when a couple forgets to use contraception, a condom breaks, a diaphragm becomes dislodged, an IUD is expelled, a woman forgets to take her oral contraceptive pills, or a woman is raped.

14. Withdrawal is an effective method of preventing pregnancy for a man who has never had sex before. (MYTH)

The effective use of withdrawal requires that a man have a high level of self-control during ejaculation. A man who is inexperienced in penile-vaginal sex will likely have difficulty removing his penis from the vagina in sufficient time before ejaculating.

15. Condoms have the highest typical-use effectiveness rate. (MYTH)

Although condoms can be effective in preventing pregnancy, many other contraceptive methods are highly effective in typical use, including sterilization, oral contraceptive pills, Depo-Provera, and Norplant implants.

Sexually Transmitted Infections (STIs)

Sexually transmitted infections (STIs) are infections that can be passed from one person to another person by sexual contact, although in some cases some STIs can be transmitted by other means as well. For example, a woman can transmit an STI to her unborn child through the placenta, or at the time of delivery as the baby passes through the birth canal. STIs can be transmitted between any two people—regardless of their sex or age—by penile-vaginal, anal, and oral sex and by skin-to-skin contact during sex. In many places in the world, STIs are referred to as **sexually transmitted diseases (STDs)**.

STIs are part of a broader group of infections known as **reproductive tract infections (RTIs)**. In addition to STIs, RTIs include other infections of the reproductive system that are not caused by sexual contact. Some of these infections result from an imbalance of the

microorganisms normally found in the reproductive tract (such as bacterial vaginosis or yeast infections); still other RTIs are incurred during medical procedures.

The symptoms associated with STIs and other RTIs vary from none to severe. You cannot always tell if a person has an STI, and people without symptoms often transmit the infection to others unknowingly.

Common STIs

STIs can be divided into two broad categories:

- **Curable STIs:** These can be treated and cured with antimicrobial drugs. However, if they are not diagnosed and treated in time, some of these diseases can cause irreversible damage, such as infertility, pelvic inflammatory disease (PID), premature labor and delivery, increased risk for cervical cancer, ectopic pregnancy, inflammation of the testes, pneumonia and other infections in infants, and, in extreme cases, death.
- **Incurable STIs:** These are caused by viruses. Although these infections cannot be cured, in some settings they can be managed by relieving or reducing their symptoms.

Partner Management

For clients with chlamydia, gonorrhea, or NGU, it is important to inform any sexual partners that they have had in the last month about the infection and to encourage these partners to come to the facility for more information and treatment. For clients with signs and symptoms of syphilis, it is important to inform any sexual partners that they have had in the last three months about the infection and to encourage these partners to come to the facility for more information and treatment.

If the client feels uncomfortable telling a sexual partner about the infection:

- Discuss or role-play what the client could say to a partner, and suggest some strategies that might help, such as:
 - Suggest that the client choose a private place where he and his partner will not be disturbed, as well as a time not associated with sex.
 - Encourage the client to tell his partner that they are discussing this important issue because he really cares about the partner.
 - Suggest that the client allow time for the partner's initial reaction, then begin talking about treatment and how to prevent future infections.
- Discuss alternative strategies for getting a partner to come to the facility, such as providing a referral card (if available).
- Offer to talk to any partners.

Risk Factors for Transmitting and Contracting STIs

Abstinence is the only way to be 100% sure of not transmitting and contracting STIs through sexual means. During unprotected sexual activity, persons are at the lowest risk for transmitting and contracting STIs by having sex *only* with partners:

- Whom they are sure are not infected with an STI
- Who have no other sexual partners

Signs and Symptoms of Common STIs

STI	Signs and Symptoms	Curable or Incurable
Chlamydia	<p><i>In men:</i></p> <ul style="list-style-type: none"> • Burning or pain during urination • Urethral discharge • Urethral itching • Swollen and/or painful testes • Some men have no symptoms. <p><i>In women:</i></p> <ul style="list-style-type: none"> • Burning or pain during urination • Unusual vaginal discharge • Abnormal and/or heavy vaginal bleeding (<i>Note: This symptom is often caused by factors other than STIs.</i>) • Bleeding after intercourse • Lower abdominal pain (pain below the belly button; pelvic pain) • Often, women have no symptoms. 	Curable
Genital warts (human papilloma virus, or HPV)	<ul style="list-style-type: none"> • Warts or bumps on the genitals, anus, or surrounding areas • In about half of all cases, clients have no perceivable warts. 	Incurable
Gonorrhea	<p><i>In men:</i></p> <ul style="list-style-type: none"> • Burning or pain during urination • Urethral discharge • Urethral itching • Swollen and/or painful testes <p><i>In women:</i></p> <ul style="list-style-type: none"> • Burning or pain during urination • Unusual vaginal discharge • Abnormal and/or heavy vaginal bleeding (<i>Note: This symptom is often caused by factors other than STIs.</i>) • Often, women have no symptoms. 	Curable
Herpes (herpes simplex)	<ul style="list-style-type: none"> • Burning or pain during urination • Blisters or ulcers (sores) on the mouth, lips, genitals, anus, or surrounding areas • Itching or tingling in the genital area 	Incurable

(continued)

Signs and Symptoms of Common STIs (continued)

STI	Signs and Symptoms	Curable or Incurable
HIV infection/AIDS	<ul style="list-style-type: none"> • May include various symptoms and opportunistic infections due to lack of immune system function 	Incurable
Nongonococcal urethritis (NGU) (This term is used to describe urethritis in men that is not caused by gonorrhea.)	<ul style="list-style-type: none"> • Pain during urination • Penile discharge 	Curable
Pubic lice	<ul style="list-style-type: none"> • Itching in the genital area or on the thighs, eyelashes, or eyebrows 	Curable
Scabies	<ul style="list-style-type: none"> • Lesions on the skin that itch, especially between the fingers and toes, in the armpits, and on the elbows, penis, and scrotum (and rarely on the back, face, and scalp) 	Curable
Syphilis	<ul style="list-style-type: none"> • Blisters or ulcers (sores) on the mouth, lips, genitals, anus, or surrounding areas • Blister-like lesions • Enlarged lymph nodes in the groin area 	Curable
Viral hepatitis (hepatitis B or hepatitis C)	<ul style="list-style-type: none"> • Jaundice (yellowing of the eyes and skin) • Fever • Headache • Muscle ache • Dark urine 	Incurable

In all other instances, engaging in the following behaviors can put a person, his or her partner(s), and his or her children at higher risk for transmitting and contracting STIs:

- Having penile-vaginal, oral, or anal sex or oral-anal contact with a person who has signs or symptoms of an STI
- Having penile-vaginal, oral, or anal sex or oral-anal contact without using a barrier, such as a male condom, female condom, or dental dam (see “Note,” below)
- Having sex with multiple partners
- Having sex with a person who has other partners
- Having sex with a person whose behavior puts him or her at high risk for contracting STIs, such as commercial sex workers and injection-drug users
- Sharing needles, syringes, or other drug paraphernalia during injection-drug use
- Having sex while using drugs or alcohol or having sex with a person who does so
- Having penile-vaginal sex with or performing oral sex on a woman who is menstruating

- Having semen in the mouth
- Sharing sexual aids (“sex toys”) without first disinfecting them
- Sharing douching equipment without first disinfecting it
- Engaging in any sexual practice that causes tissue damage or bleeding (e.g., dry sex, anal sex)

Note: A **dental dam** is a square piece of thin latex that can be used while performing oral and oral-anal sex on a woman to prevent the transmission of STIs. If a dental dam is not available, a thin piece of plastic wrap or a male condom cut lengthwise can be used.

Levels of Risk

Different sexual behaviors carry different levels of risk for transmitting and contracting STIs. If an individual is not sure whether or not his or her partner is infected with an STI, explain that the sexual behaviors in the chart on page 3.37 indicate various levels of risk.

Note: The risk between categories is not to scale, and the order of activities within a bar is not necessarily representative of any order in the risk of activities. Risks may vary somewhat from one type of infection to another; for example, condoms protect against gonorrhea but do not protect against syphilis, herpes, or genital ulcers unless the condom is covering the lesions. Risk levels also vary based on context and different experts’ opinions. The examples are provided simply as a framework.

Reducing Risk

Sexual behaviors occur along a continuum of risk, ranging from no risk to very high risk. This applies to different sexual behaviors, as well as to the various ways in which a person can perform any sexual behavior.

Harm Reduction

Harm reduction is an approach individuals can use to reduce their risk for contracting STIs. When using this approach, individuals take whatever steps they can to reduce the potential risk of a sexual behavior if they cannot or will not abstain from the behavior or if they cannot or will not have sex only with a mutually monogamous partner whom they are sure is not infected with an STI.

A harm-reduction approach:

- Focuses on changing behavior in order to reduce risk rather than attempting to completely eliminate the behavior or engage only in the safest sex practices
- Recognizes that people are willing to accept different levels of risk in their lives, and that the safest way of having sex may not be acceptable to everyone
- Acknowledges that some ways of having sex are clearly safer than others. For example, while abstaining from performing oral sex on a man is safest, using a condom during oral sex is the next safest alternative. But an individual has several ways to reduce the risk if these practices are not acceptable. For example, having oral sex without ejaculate in the mouth is safer than having oral sex with ejaculate in the mouth.
- Requires that people are given the information necessary to make informed decisions on their own

Levels of Risk					
<ul style="list-style-type: none"> • Abstinence • Hugging • Massage • Masturbation • Fantasy • Phone sex • Cyber sex • Dry kissing • Not sharing sex toys • Sex with a monogamous, uninfected partner 	<ul style="list-style-type: none"> • Sexual stimulation of another's genitals using hands • Giving a man oral sex without putting head of penis in mouth • Giving or receiving oral sex with a condom, dental dam, or plastic wrap • Receiving oral sex without a barrier • Sharing sex toys with cleaning or use of new condom • Tongue kissing 				
<ul style="list-style-type: none"> • Insertive or receptive vaginal sex with a condom • Insertive anal sex with a condom 	<ul style="list-style-type: none"> • Receptive anal sex with a condom • Giving oral sex without a condom, dental dam, or plastic wrap (safer if no ejaculation in the mouth) • Sharing sex toys without cleaning or use of new condom • Sexual stimulation of another's genitals using hands with cuts or broken skin (safer if no contact with secretions, semen, or menstrual blood) 				
<ul style="list-style-type: none"> • Insertive anal sex without a condom • Insertive vaginal sex without a condom 	<ul style="list-style-type: none"> • Receptive anal sex without a condom • Receptive vaginal sex without a condom 				
No Risk	Very Low Risk	Low Risk	Medium Risk	High Risk	Very High Risk

Source: Adapted from *As safe as you wanna be*. Seattle-King County Dept. of Public Health.

People accept different levels of risk to satisfy personal needs. While not everyone will follow every safer-sex recommendation, having adequate knowledge about the risks enables each person to make his or her own informed choices about reducing sexual risks.

Safer Sex

Safer sex includes practices that reduce the risk for contracting STIs, including HIV infection. These practices reduce contact with the partner's body fluids, including ejaculate from a man's penis (semen), vaginal fluids, blood, and other types of discharge from lesions or open sores.

As stated earlier, during unprotected sexual activity, individuals are at the lowest risk for contracting STIs by having sex only with partners whom they are sure are not infected with an STI and who have no other sexual partners.

With all other partners, safer-sex practices include:

- Using a barrier to cover the penis, vagina, hands, or any objects that are inserted into or come in contact with the vagina, anus, or rectum during every act of penile-vaginal, oral, or anal sex or oral-anal contact
- Avoiding sex with partners who have sores on their genitals or abnormal discharge from their genitals
- Avoiding oral sex with partners who have sores in their mouths
- Avoiding inserting fingers into the vagina or rectum if open sores are present on the hands or fingers
- Reducing the number of sex partners
- Avoiding sex with individuals who have multiple partners
- Avoiding sex with individuals whose behavior puts them at high risk for contracting STIs, such as commercial sex workers and injection-drug users
- Avoiding sharing needles, syringes, or other drug paraphernalia during injection-drug use
- Avoiding sex while using drugs or alcohol or with persons who do so
- Avoiding having penile-vaginal sex or performing oral sex on a woman who is menstruating
- Avoiding having semen in the mouth
- Avoiding sharing sexual aids ("sex toys") or douching equipment without disinfecting them between uses
- Avoiding any sexual practice that causes tissue damage or bleeding

Barriers to cover the penis, vagina, hands, or objects used during sexual activity include a male condom, a female condom, a dental dam, a thin piece of plastic wrap, or a cut-open male condom.

Dual Protection

Many service providers are promoting the concept of **dual protection** to prevent against the transmission of STIs, including HIV infection. Dual protection is a strategy that prevents both STI/HIV transmission and unintended pregnancy through the use of condoms alone, the use of condoms combined with other methods (dual-method use), or the avoidance of risky sex (Spieler, Karra, & Bogelsong, 2000; EngenderHealth, 2002). More specifically, dual protection can include:

- The use of condoms (male or female) alone for both purposes
- Dual-method use:
 - The use of a condom plus another contraceptive method for extra protection against pregnancy
 - The use of a condom plus emergency contraception if the condom breaks
 - Selective condom use (choosing to use condoms with some partners and not others, depending either on the perception of the level of risk or on the context of the sexual activity and access to condoms) plus another contraceptive method (for example, using only the pill with a primary partner and using the pill plus condoms with secondary partners)
- The avoidance of risky sexual activity:
 - Abstinence
 - Avoidance of all types of penetrative sex
 - Mutual monogamy between uninfected partners combined with the use of a contraceptive method for those who want to avoid pregnancy
 - Delaying sexual debut (for young people)

Condom promotion is important for dual protection for the following reasons:

- The male latex condom, when used consistently and correctly, is the only technology that has been proven to be highly effective in preventing STI/HIV transmission and pregnancy at the same time.
- The female condom may be as effective as the male condom, but there is not enough data to support this claim at this time.

Legitimizing condoms as an effective contraceptive method is important for the following reasons:

- In some cases, pregnancy prevention can be a greater motivator for condom use than STI/HIV prevention.
- If family planning programs promoted condoms as an effective method of pregnancy prevention, this approach would reduce the stigma associated with the condom as a method of STI/HIV prevention.
- In general, many service providers who offer family planning services believe that condoms are not effective for pregnancy prevention, but that they are effective for STI/HIV prevention. In part, this bias exists because other family planning methods—such as sterilization, IUDs, injectables, and implants—are more effective than condoms in both perfect use and typical use. But when condoms are used consistently and correctly, they are highly effective against pregnancy. This fact needs to be communicated to service providers and clients alike.
- Data show that from a single act of unprotected penile-vaginal sex, the probability of acquiring various STIs is much greater than the probability of becoming pregnant. So if condoms are used consistently and correctly to prevent STIs, they must be even more effective against pregnancy.
- Condoms (and those who use them) are stigmatized because they are currently associated with STI/HIV prevention and their use implies that partners may have other sex-

ual partners. The stigma from associating condom use and sex work or sexual promiscuity can be addressed by promoting condoms as effective methods for both pregnancy and STI/HIV prevention.

Dual-protection counseling is important in family planning services for the following reasons:

- Many family planning clients may be at risk for STI/HIV infection as well as unintended pregnancy. Many women are at risk for STIs/HIV mostly as a result of their partners' risky sexual activities. Dual-protection counseling can help clients perceive their own risk for STIs/HIV and unintended pregnancy and develop strategies to protect themselves.
- Meeting clients' needs for dual protection improves the quality of sexual and reproductive health services by addressing clients' multiple concerns.
- Pregnancy and STI/HIV prevention needs are inseparable and should be addressed together.

Dual-protection counseling relates to the concept of informed choice:

- Dual-protection counseling upholds the concept of informed choice by making sure that clients are knowledgeable about and aware of their risks for STIs/HIV and unintended pregnancy while making family planning decisions.
- Clients are not making truly informed choices about family planning unless they are aware of their risks for STIs/HIV and are knowledgeable about how effective the various family planning methods are in STI/HIV prevention. Dual-protection counseling ensures that clients are aware, knowledgeable, and informed.

Key strategies for dual-protection counseling in a family planning setting include:

- Working with clients on partner communication and condom negotiation skills
- Involving men in counseling and education and addressing their concerns about condoms
- Eroticizing condom use and making it appealing to both partners
- Helping women consider the ramifications of their decisions—both positive and negative—and recognizing the limitations that many women may have in negotiating condom use (for example, insisting on condom use may lead to violence and/or abandonment)
- Promoting the female condom as a viable contraceptive method (where it is available)

Gender and STIs

Being male or female can affect an individual's risk for contracting STIs, the seriousness of an STI's complications, his or her ability to receive adequate treatment for an STI, and his or her experience of having an STI. These differences are explained below.

Physical Differences between Women and Men

- Women are more likely than men to acquire an STI from any single act of unprotected penile-vaginal sex because the semen remains in the vagina for an extended amount of time after sex. This increases the opportunity for infection. In addition, the interior wall of the vagina is more vulnerable to cuts or tears that could easily transmit STIs than the penis, which is less vulnerable because it is protected by skin.
- Many STIs produce no symptoms in women, produce symptoms (such as discharge) that may not be identified as being related to an STI, or produce symptoms that are not

easily seen because they appear inside a woman's body. As a result, women often do not seek treatment for STIs and may suffer greater long-term and permanent physical effects from STIs than men.

- If left untreated, STIs are more likely to cause serious complications in women than men. **Pelvic inflammatory disease (PID)** that results from an untreated STI in women can lead to infertility, ectopic pregnancy, and chronic pelvic pain. Cervical cancer is also the result of an untreated STI.
- Women can pass STIs to a fetus, which may result in miscarriage, stillbirths, and infections in newborns. These infections, in turn, can cause blindness, pneumonia, other illnesses, or death.

Socially Constructed Expectations of Male Behavior

- Often, social expectations about men's sexual behavior can result in men engaging in risky behaviors, such as having unprotected sex and sex with multiple partners. This behavior can contribute to men transmitting STIs to their female partners.
- Many men have concerns about how to tell their wives that they have an STI. Men may fear that their wives will ask where the STI came from, which may put the men in an uncomfortable situation if they have other partners that they have not mentioned to their wives.
- Men are not accustomed to seeking reproductive health care and are often uncomfortable accessing reproductive health services. This may be because they view the services as being for women only or because they have been socially conditioned to believe that an important part of being a man is to be "strong" and not ask for assistance.

Power Imbalances between Women and Men

- Power imbalances and social expectations of how women should behave may make it difficult for women to discuss sex with or mention reproductive health concerns to their partners. As a result, women may not ask their partners to use condoms and may not be allowed to refuse sex, even when they know that it will put them at risk for pregnancy or STIs. In general, women may yield to their partner's wishes about sex-related issues to avoid being yelled at, divorced, beaten, or killed.
- Women are often afraid to tell their husbands or partners that they have an STI, even when their husband or partner transmitted it to them. If they do so, many women may experience physical, mental, or emotional abuse or divorce.
- Men may restrict women's access to services by limiting their financial resources, mobility, and access to information about services.

STI Myths and Facts

Clients and service providers may believe or want more information about the following statements about STIs. Some of the statements are true, and some are false. Each statement is followed by the term *myth* or *fact*, depending on whether it is false or true, and a brief explanation.

1. A man cannot transmit an STI if he withdraws before ejaculation. (MYTH)

Withdrawal does not eliminate the risk for transmitting STIs. Pre-ejaculatory fluid from the penis can contain infectious organisms, and organisms on the skin of a man's genitals can be transmitted to another person.

2. It is possible to get an STI from having oral sex. (FACT)

The person performing and the person receiving oral sex are at different levels of risk. The person receiving oral sex is at risk only if his or her partner has an open sore or ulcer in the mouth or on the face or has an STI in the throat. The person performing oral sex is at high risk if he or she has an open sore on the lips or face or if he or she has ejaculate or vaginal fluids in the mouth. To protect against STIs, an individual should always use a latex or plastic barrier, such as a male condom, female condom, or dental dam, when having oral sex.

3. A monogamous person cannot contract an STI. (MYTH)

Individuals who are faithful to their partners may still be at risk for contracting STIs if their partners engage in sexual activity with other people. In addition, individuals who are currently monogamous with their partners may have contracted an STI from someone else in the past; therefore, they may have an STI without knowing it and/or without telling their current partners.

4. If you have an STI once, you become immune to it and cannot get it again. (MYTH)

Contracting an STI does not make a person immune to future infections. If a person is treated and cured but his or her partner(s) is not treated, the cured person can get the infection again. The cured person can also get the infection from another partner. Repeat infections can put people at risk for damage to the genital tract (e.g., scarred fallopian tubes) or chronic infection (e.g., chronic PID).

5. You can become infected with more than one STI at a time. (FACT)

A person can have more than one STI at the same time. For example, more and more people are now contracting chlamydia and gonorrhea together.

6. You cannot contract AIDS by living in the same house as someone who has the disease. (FACT)

HIV, the infection that causes AIDS, is transmitted through exposure to infected blood and other infected body secretions. Living in the same house with someone who is HIV-infected does not put those in contact with him or her at risk unless they share items that have been exposed to the infected person's blood or genital secretions (e.g., through the use of common toothbrushes, razors, or douching equipment).

7. You can always tell if someone has an STI by his or her appearance. (MYTH)

Sometimes, STIs produce no symptoms or no visible symptoms. In fact, many people carry STIs for long periods of time without knowing that they are infected. In addition, no type of person is immune from STIs. People of different races, sexes, religions, socioeconomic classes, and sexual orientations all contract STIs.

8. Condoms reduce the risk for contracting STIs, including HIV infection. (FACT)

After abstinence, latex condoms are the most effective way to prevent STIs, including HIV infection. However, latex condoms are not 100% effective. Some groups have reported inaccurate research that suggests that HIV can pass through latex condoms, but this is not true. In fact, laboratory tests show that no STI, including HIV, can penetrate latex condoms (Gardner, Blackburn, & Upadhyay, 1999).

9. A person infected with an STI has a higher risk for transmitting and contracting HIV infection. (FACT)

Both ulcerative STIs (those that cause sores) and nonulcerative STIs increase the risk

for transmitting and contracting HIV infection. Ulcerative STIs increase the risk for HIV infection because the ulcers provide easy entry into the body via the HIV virus. Nonulcerative STIs may enhance HIV transmission for two reasons: They increase the number of white blood cells in the genital tract, and genital inflammation may cause microscopic cuts that can allow the HIV virus to enter the body.

10. STIs are a new medical problem. (MYTH)

STIs have existed since the beginning of recorded history. Evidence of medical damage caused by STIs appears in ancient writings, art, and skeletal remains.

11. Herbal treatments are effective in curing STIs. (MYTH)

Antibiotics are the only proven effective treatment for bacterial STIs, which include chlamydia, gonorrhea, and syphilis. Currently, no cure exists for viral STIs, which include genital warts, hepatitis, herpes, and HIV. Often, clients who receive STI care from nonmedical personnel believe that their STI has been treated, but this is not so. This misconception prevents them from getting adequate treatment, which puts their health and the health of their partner(s) at great risk.

12. People usually know that they have an STI within two to five days of being infected. (MYTH)

Many people never have symptoms, and others may not have symptoms for weeks or years after being infected.

13. Abstinence is the only 100% effective safeguard against the spread of STIs. (FACT)

Abstinence from sex is the best way to prevent the spread of STIs. However, latex condoms are the next best option. When used consistently and correctly, these condoms prevent the transmission of STIs very effectively.

14. It is possible to get some STIs from kissing. (FACT)

It is rare but possible to get syphilis through kissing if the infected person has chancres (small sores) in or around the mouth. Kissing can also spread the herpes virus.

15. Youth are particularly vulnerable to STIs. (FACT)

STIs are disproportionately higher among young people than adults for both biological and behavioral reasons. The highest reported cases of STIs are among young people (ages 15 to 24). In developed countries, two-thirds of all reported cases of STIs occur among those under age 25 (“Trends in Youth Sexual and Reproductive Health Programming,” 2001; FOCUS on Young Adults, 2000).

16. Anal sex is the riskiest form of sexual contact. (FACT)

Anal intercourse carries a higher risk of HIV transmission than other types of sexual contact. During anal sex, the penis can tear the mucous membrane of the anus, which provides the virus with an entry point into the bloodstream.

17. Special medicines can cure HIV infection. (MYTH)

Currently, there is no cure or vaccine for HIV infection. Some drugs can slow down the production of the virus in an infected person, but these drugs are expensive and difficult to access.

18. HIV is a disease that affects only sex workers and homosexuals. (MYTH)

Anyone can become infected with HIV. A person’s risk for HIV is not related to the type of person he or she is, but rather to the behavior he or she engages in.

19. HIV can be transmitted from one person to another when sharing needles for drugs. (FACT)

Sharing needles during injectable drug use carries a very high risk of HIV transmission. Infected blood is easily passed from one person to another via an infected needle or other equipment used to prepare or inject drugs.

20. A man can be cured of an STI by having sex with a girl who is a virgin. (MYTH)

Proper treatment is the only way to cure or manage the symptoms of STIs. STIs cannot be cured by transmitting them to others. Having sex with a virgin or anyone else only increases that person's risk for infection.

Cancers of the Reproductive System

Several cancers can affect the male reproductive health system, including prostate and testicular cancer. It is important to educate male clients about both types of cancers in order to detect them early and help the clients get the necessary treatment.

Prostate Cancer

The normal function of the prostate gland is to produce secretions that help to nourish sperm. The prostate gland needs testosterone, which is the male hormone that is produced by the testes, to make it grow and function properly.

Prostate cancer occurs when some of the cells that make up the prostate gland escape from the normal controls on their growth and start to divide, grow, and spread in an uncontrolled manner. The causes of prostate cancer are unknown, but they may include genetic predisposition, hormonal influences, dietary and environmental factors, and infectious agents.

In addition to increasing a man's risk for developing cancer, the prostate gland can cause difficulties through gradual enlargement, which occurs in most men as they get older. (The incidence of prostate cancer rises steadily with age; prostate cancer is rare in men under age 40.) This condition, called **benign prostatic hyperplasia (BPH)**, makes urination more difficult and frequent, particularly at night. It is very difficult to differentiate between BPH and prostate cancer based upon symptoms alone, and service providers should always refer their client to a doctor if a client is experiencing any of these symptoms.

Symptoms of Prostate Cancer

At first, the cancer grows slowly and is usually limited to within the prostate gland. During the course of the illness, the prostate cancer cells can spread around the body, particularly to the bones, where they can cause pain. Estimates show that the cancer may have been growing in some men for up to 10 years before it causes symptoms and is diagnosed. Some men develop symptoms while others do not, or are **asymptomatic**. Those men who do may experience the following symptoms:

- Frequent need to urinate, especially at night
- Urgent need to urinate
- Difficulty beginning and stopping the flow of urine
- Dribbling, hesitant, thin stream of urine

- Sensation that the bladder is not emptied
- Inability to urinate
- Involuntary loss of urine (incontinence)
- Lower back pain
- Blood in the urine (rare)

There appear to be several forms of prostate cancer. Some men survive for many years with the disease and never develop symptoms. These men may not know that they have a slow-growing form of prostate cancer and may eventually die of other causes. However, other prostate cancers can be more aggressive and can grow quickly.

Diagnosing Prostate Cancer

Since prostate cancer can be asymptomatic, a number of tests are used in an effort to diagnose the disease before it begins to cause symptoms. One of the tests most frequently used is the **PSA (prostate specific antigen) test**, which identifies the levels of a particular prostate protein found in the blood. Raised levels of this protein can indicate a problem with the prostate gland, but this does not necessarily mean that cancer is present. In combination with this test, a service provider often performs a rectal examination to help determine the size, shape, and texture of the prostate gland. Some providers currently recommend that men over age 50 have a regular screening that usually consists of a rectal examination and a blood test.

Treating Prostate Cancer

The age of the man and his side effects will play a large role in treatment choices. For older men with slow-growing prostate cancer, a service provider may choose to simply monitor the client's symptoms and disease before choosing among the following treatments:

- **Radical prostatectomy:** This is the removal of the prostate gland and seminal vesicles when the cancer is confined to the prostate. Side effects may include infection, urinary incontinence, and erection problems.
- **Radiation therapy:** This may be used to treat small tumors or cancers that have spread beyond the prostate gland. Side effects include rectal, urinary, and erection problems.
- **Hormone therapy:** This treatment may be used for men who cannot have surgery or radiation.

Preventing Prostate Cancer

Some behaviors that may help reduce the risk for prostate cancer include (Prostate Cancer Charity Web Site; Inlander & the People's Medical Society, 1999):

- Maintaining a healthy weight
- Eating less fat
- Eating green, leafy vegetables that are rich in beta carotene, such as spinach and broccoli
- Eating tomatoes, which are rich in lycopene

Testicular Cancer

Testicular cancer is cancer of the testes, or testicles, which produce testosterone and sperm cells. It is a relatively rare form of cancer, but is the most common form of cancer in

men between ages 20 and 34. Testicular cancer is one of the most treatable forms of cancer, with cure rates approaching 100% if detected early.

Testicular cancer commonly occurs when **germ cell tumors (GCTs)** grow in sperm-producing cells. The cause of GCTs is not known, although one notable risk factor is the failure of a testicle to descend into the scrotum during infancy. This is known as **cryptorchidism**, and greatly increases the risk for developing testicular cancer.

Symptoms of Testicular Cancer

The most common symptom of testicular cancer is a painless swelling or lump in one testicle. About a third of the time, a man may experience a dull ache or a feeling of heaviness in the lower stomach, scrotum, or groin area. All men should be familiar with the size and feeling of their testes, so they can detect any type of change.

Diagnosing Testicular Cancer

The best way to diagnose testicular cancer is through self-examination. It is recommended that men conduct self-examinations on a monthly basis after age 15. The most common initial symptom is a painless lump in or on the testicle and/or a hardness or enlargement of the testicle. Associated pain and tenderness are less common symptoms.

If problems do occur and an individual is concerned because of tenderness, bloody discharge, or a lump, he should see a service provider. The provider will perform a physical examination and possibly conduct a testicular ultrasound (Urology Channel Web Site).

Treating Testicular Cancer

Treatment depends on the stage of the disease, but it may include surgery, radiation therapy, and chemotherapy. If there is a concern about cancer, a service provider may conduct a **biopsy**, which includes the removal of the suspected testicle from the scrotum. Removing the testicle will prevent the spread of the cancer and will not affect the man's fertility or sexual functioning.

Surgery, or **orchiectomy**, which is the surgical removal of the affected testicle, is part of the diagnostic process as well as the first step in treating testicular cancer. Since testicular cancer rarely occurs in both testes, a client's remaining testicle can maintain hormone levels and fertility. Surgery is sometimes all that is needed in treating testicular cancer.

In more advanced cases, chemotherapy or radiation treatments may be necessary. Radiation therapy is particularly effective for **seminomas**, which are composed of immature germ cells. Chemotherapy is generally used for clients with **nonseminomas** and limited **metastasis**, the process by which cells break away from the original tumor and spread to other parts of the body.

Preventing Testicular Cancer

Again, the most effective way to prevent testicular cancer is to catch it early through consistent testicular self-examination on a monthly basis.

A testicular self-exam is best conducted after a warm shower or bath and consists of the following steps (Inlander & the People's Medical Society, 1999):

1. Make sure the scrotal skin is relaxed.
2. Roll each testicle between the thumbs and fingers of both hands.

3. Massage the surface lightly to check for any irregularities or anything that seems unusual. Areas that are tender or swollen may indicate an infection. You may feel the epididymis, a structure along the back of each testicle; this is normal.
4. Contact a service provider as soon as possible for more extensive testing if you find any irregularities, bumps, or hard lumps.
5. Note any changes from month to month, and alert a service provider if you detect any changes.

Infertility

A couple or individual is considered infertile if the man and/or the woman have been unable to achieve a pregnancy after one year of unprotected intercourse. Scientific data indicate that in approximately 30% of the cases, infertility is a result of a problem in the man's reproductive system, while in another 20% of the cases, infertility can be due to the functioning of both the man's and the woman's reproductive system.

Causes of Male Infertility

Most male infertility is caused by a low sperm count or **motility** of the sperm, which is the sperm's ability to swim into a woman's fallopian tube and fertilize an egg. The following factors can affect sperm count and motility:

- Illnesses, such as the flu or mumps, can decrease the production of sperm
- STIs, which can affect the testes or the spermatic ducts
- Environmental toxins
- Smoking and alcohol and drug use can decrease sperm production
- Varicoceles, which are damaged or enlarged veins near the spermatic cord that can decrease sperm counts by increasing heat in the testes
- Congenital problems
- Chromosomal defects
- Hormonal insufficiency

Diagnosing Male Infertility

A service provider may refer a man to a urologist to determine the possible causes of infertility. The urologist may perform several tests, including:

- **Sperm analysis** to test the semen volume, consistency, number of sperm, motility, and sperm shape
- **Postcoital test** to check the compatibility of the man's sperm with a woman's cervical mucus
- **Blood tests** to check for hormone imbalances
- **X-rays** to look for damage and blockage of the vasa deferentia

Preventing Male Infertility

There are some things a man can do to improve his fertility, including (Inlander & the People's Medical Society, 1999):

- Avoiding stress
- Not using alcohol or drugs
- Not smoking

- Checking medications that may affect fertility
- Taking antioxidants
- Getting enough zinc
- Eating plenty of fruits, vegetables, and whole grains
- Avoiding environmental toxins
- Wearing loose-fitting undergarments

Substance Use and Sexual and Reproductive Health

While men may choose to use alcohol or other drugs as a way to enhance their sexual activity by lowering inhibitions, many substances, such as alcohol, actually lead to impairment of sexual functioning. This includes difficulty in achieving or maintaining erections, and orgasmic and ejaculatory problems. Alcohol is a depressant, and while some men may believe it may make them last longer sexually (delay ejaculation), it is more likely to lead to erection problems.

Alcohol and drug use may also impair a person's judgment, leading to high-risk sexual behaviors, including unprotected sexual activity. There is a link between the use of alcohol or other substances and the potential risk for not using condoms and becoming infected with an STI, including HIV. Longer-term use of alcohol or other substances could lead to problems with sperm production and fertility. Some prescription medications, such as those for treating depression, anxiety, ulcers, and high blood pressure, may also affect sexual functioning, including difficulty achieving erections.

Service providers should be sure to ask about a client's use of alcohol, other substances, and any medical prescriptions, especially if the client is reporting any problems with sexual functioning. Providers should also educate men about how alcohol and other substances negatively affect a man's sexual functioning and decision making, increasing the risk for erectile dysfunction, STIs, and possibly infertility. In addition, providers should ask about any medications a client may be using to try to enhance his sexual performance or to combat any sexual dysfunction. Many times, these medications do nothing to help with sexual functioning or, at worst, may negatively affect a man's sexual and reproductive health.

The effects of alcohol and drug use on men's sexual and reproductive health include the following:

- Reduces libido
- Lowers inhibitions, leading men to engage in high-risk sexual behaviors
- Increases the likelihood of inconsistent or incorrect condom use, increasing the risk for transmitting and contracting STIs, including HIV infection
- Dilates blood vessels, making it harder for blood to reach the penis for an erection, which leads to erectile dysfunction or impotence
- Impairs men's ability to have an orgasm
- Reduces sperm production or increases production of damaged sperm

In addition, long-term alcohol use leads to decreased levels of male sex hormones. Prolonged alcohol abuse has also been shown to cause irreversible damage to the nerves in the penis, which results in ongoing erection problems.

4

Effective Techniques for Counseling Men and Couples

This chapter begins with an overview of the gender issues that service providers face when providing counseling services to men. It also describes effective techniques for communicating with individual men and with couples in a counseling setting.

Gender Perspective Overview

Offering counseling services to men, either alone or with their partners, requires service providers to bring a “gender perspective” to their interactions with men. The following points form the basis for this gender perspective:

- Gender refers to what a person, society, or legal system defines as “female” or “male.”
- Gender roles refer to the set of socially or culturally defined attitudes, behaviors, expectations, and responsibilities that is considered appropriate for women (feminine) and men (masculine). Gender roles may vary according to culture, class, and ethnicity. For example, in some cultures, being a man means being strong, dominant, and unemotional, while being a woman means being sensitive, nurturing, and passive. These roles are a powerful force.
- Gender affects the amount of power an individual has in society and in relationships.
- While it is generally true that men wield more power than women, it is important not to assume that all men fit the narrow stereotype of “controlling partner.”
- Gender and gender roles affect communication, both between partners discussing sexual and reproductive health issues within their relationship and between clients and service providers.
- Service providers who understand the different ways in which men and women communicate will be able to more effectively counsel men as individuals and as partners.
- Involving men in sexual and reproductive health services can promote gender equity and support the sharing of power within relationships, but service providers must be careful not to have a negative impact on women’s access to services. For example, sometimes when a couple comes in for counseling, providers focus more on the male client than the female client, to the detriment of the woman.

In some settings, service providers use a reality-based approach to sexual and reproductive health services that recognizes men’s authority within the family and community. When providers use this approach to try to influence men’s authority—at the same time that they acknowledge this authority—in order to benefit both women and men, it is most likely to have positive sexual and reproductive health outcomes.

Understanding Men's Needs and Roles

Service providers who have recently begun offering sexual and reproductive health services to men often report wanting more training on how to talk to men during counseling sessions. Many providers are aware that talking to men about sexuality issues may be different from working with women during traditional family planning counseling. While it is impossible to identify some general communication approaches that work best for all men, having an understanding of men's needs and roles can help providers to more successfully engage men in discussions of sexual and reproductive health, particularly sexuality.

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

Many Men Are Decision Makers

Men are usually socialized to act decisively and to be in control, and generally feel more comfortable if they can solve their problems on their own. They may feel a conflict when they visit a health care facility, are told to undergo a physical examination, and then are given treatment, to have their problem solved for them. Service providers can help reduce this conflict by affirming a male client's appropriate health-seeking behavior and then questioning him about how he might solve his problem. If the client is not sure how to do this, the provider can help to affirm his ability to find solutions by asking him how he has solved other problems in his life. If he still is not sure, the provider can suggest actions for solving problems, rather than telling the client what to do or giving him orders.

The following client-provider interaction (CPI) shows one way to successfully handle this type of situation.

Scenario: A man comes to a health care facility because he had unprotected sex and is concerned that he may have contracted a sexually transmitted infection (STI).

What might not work: Simply telling the man that unprotected sex puts him at risk for STIs, showing him how to use a condom, giving him condoms, and then telling him he needs to use a condom every time he has sex may not be effective.

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

Many Men Are Reluctant to Appear Ignorant

Men are often socialized to appear as if they know everything about sex. Admitting that they might not know something, especially something related to sex, may create anxiety for men who are concerned about their sense of manhood, and, therefore, many men are not likely to ask questions during a visit to a health care facility. During a counseling session, this might be apparent if the service provider expects the client to answer such questions as "Do you have any questions about that?" or "Do you understand what I am saying?" or to

ask for clarification on issues. For example, when a provider is talking with a client about condoms, the client might not ask questions about how to use a condom.

One technique service providers can use to address this problem is to make it acceptable for men not to know everything on the topic. Instead of asking men to acknowledge what they do *not* know, providers can take the burden off them by actively giving information to them.

The following CPI shows one way to successfully handle this type of situation.

Scenario: A service provider is about to demonstrate how to use a condom correctly.

What might not work: Asking a man if he knows how to put on a condom correctly, having him tell you “Yes,” and then not performing the demonstration will not be effective. Neither will performing a condom demonstration and then asking the man, “Do you have any questions?”

What might work: Tell the man, “I am sure you already know how to put on a condom correctly, but I will just review a few important points about what some men struggle with.”

Many Men Are More Comfortable with Thinking than with Feeling

Generally, men are more comfortable with concrete, cognitive thinking than with discussing and processing their feelings. During a counseling session, this is apparent when a service provider focuses on thoughts and decision-making steps instead of processing and discussing emotions. If a provider asks a man how he *felt* when he found out his partner was pregnant, the man might not quickly respond with a description of his feelings. But if the provider asks the man what *thoughts* were going through his mind when he learned about the pregnancy, he may be more likely to begin discussing what he experienced. He may also be more comfortable talking about what he thinks he should do in relation to the pregnancy than how he feels about the pregnancy and the effect it is having on him.

The following CPI shows one way to successfully handle this type of situation.

Scenario: A man comes to a health care facility to get tested for STIs. During the screening process, he reveals that his partner has just found out that she is pregnant. It is an unintended pregnancy.

What might not work: Saying, “Your partner just found out she is pregnant? How do you feel about that?” is not effective.

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

Many Men Are Reluctant to Discuss Their Feelings

Many men feel uncomfortable when service providers ask them to express their feelings and to talk openly before receiving attention for what they consider to be their needs. A man

is likely to feel more comfortable, confident, and open to discussing his confusion and fears, as well as other issues, after his immediate needs have been met. He might also feel more comfortable if a provider validates that his fears or concerns are normal and that other men have shared similar sentiments. If a provider suspects that a man has a concern about an issue that he is not communicating, the provider can talk about the issue in terms of what other men have shared during a counseling session.

The following CPI shows one way to successfully handle this type of situation.

Scenario: A man has come to a health care facility for STI screening. After his exam is completed, you notice that he is looking through a brochure about erectile dysfunction that is on the desk.

What might not work: Saying, “Are you looking at that brochure on erectile dysfunction? Is there something you want to talk about?” is not effective.

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

The chart on page 4.5 illustrates sample phrases that service providers can use with male clients when discussing their needs and roles.

Responding to Issues That May Arise during Individual Counseling Sessions

While it is impossible to anticipate all the issues that may arise during individual counseling sessions with men, certain issues, or themes, tend to present themselves in relation to men’s anxieties and insecurities about or discomfort with discussing sexuality during a counseling session. The following chart outlines the issues, underlying causes, and strategies and suggestions for responding to men during counseling sessions. Service providers may need to adapt these responses to their own style; their intuition, which is based on their specific experiences; and their cultural context. In certain situations, the service provider’s gender may be a factor in his or her interaction with a male client; possible responses are offered for these situations as well.

Sample Phrases to Use When Addressing Men about Their Needs and Roles

Need or Role	Sample Phrase
Men are decision makers and want to solve their own problems.	<ul style="list-style-type: none"> • “You made a good decision to come here for help today.” • “You made a good decision to use a condom that time.” • “You made a good decision to talk to your partner about contraception.” • “How will you let the people you have had sex with know that they need to come in to be checked for this infection?” • “How do you plan to talk to your partner about this problem?”
Men are supposed to know everything about sex.	<ul style="list-style-type: none"> • “You may already know this, but....” • “You have probably heard this before, but I have to tell all my clients that....” • “I am sure you already know how to put on a condom correctly, but I will just review a few important points about what some men struggle with.” • “Let me just point out a few tips for you.”
Men might not ask questions about sex.	<ul style="list-style-type: none"> • “The other day, a man came in and asked me about erectile dysfunction. Let me tell you what I told him.” • “Even when we have dealt effectively with a problem, we sometimes have a few remaining doubts afterward. Is there anything more you would like to discuss with me?” • “You seem to understand in general how to use condoms, but are there any points you would like to know a little more about?” • “As long as you are here today, is there anything you would like to ask or tell me about?”
Men want to know that they are “normal” and are as good as or better than other men.	<ul style="list-style-type: none"> • “Many men are concerned about the same thing.” • “Many men have asked that question before.” • “A lot of men wonder about that.”
Men may need validation for asking questions about sex.	<ul style="list-style-type: none"> • “That is a really good question.” • “I am glad you asked about....” • “You are really brave to ask about....” • “It is great that you came here to get more information about....”

Some Strategies and Possible Responses for Addressing Issues That May Arise during Individual Counseling Sessions

ISSUE 1

A male client questions a service provider on his or her knowledge about or ability to relate to male sexuality or sexual and reproductive health.

Cause

The client may be addressing his feelings of unhappiness or loss of control by questioning the service provider's competence. The client may be trying to shift the focus off himself.

What a man might say

- "What would you know about my problems?"
- "I do not think you would really understand what I am going through."
- "This place only knows how to deal with women's problems."

Strategy

- Validate the client's concern and desire for understanding.
- Acknowledge your ability to work and experiences with working with men.
- Acknowledge the client's good decision to come for counseling, and encourage him to share more about the reason for his visit.

Possible response

"Although it can be challenging for someone to completely understand another person's problems and experiences, I have been trained to work/have worked with male clients and have been able to help many men like you in the past. You made a good decision to come here, and I believe I can help you if we talk a little bit more about why you are here today."

Gender consideration

This issue may arise if a man questions a female service provider's ability to understand or relate to men's problems or sexuality. Female providers can validate the concern but should acknowledge their training, experience, and success with helping men.

ISSUE 2

A male client seems embarrassed to discuss his sexual history.

Cause

The client may be uncomfortable discussing sexuality in a health-related context. He may be uncomfortable with or afraid of discussing or ashamed to discuss his sexual practices. He may also be concerned about confidentiality.

What a man might say

- "I am not sure I am really comfortable talking about these things."
- "Why do you need to know about that?"
- "What are you writing down?"

Strategy

- Validate the client's discomfort by acknowledging that most men feel uncomfortable initially when discussing sexuality.
- Assure the client that his discussion with you is confidential.
- Explain that you are writing down only information that might help you to help him with his problem.
- Offer to not write down anything if it will make the client feel more comfortable.

Possible response

"A lot of men are uncomfortable initially when talking about sexuality issues with anyone, let alone with a service provider they do not know very well. The other day, a man came in who

(continued)

Some Strategies and Possible Responses for Addressing Issues That May Arise during Individual Counseling Sessions (continued)

at first felt the same way you do, but once we talked a little bit about the reason he came to the facility, I was able to help with his problem. I am hoping I can do the same for you. Everything we discuss is confidential. No one else will know about it. If it makes you feel more comfortable, I do not have to write down anything in your chart.”

Gender consideration

This issue may arise for a male service provider if a male client feels uncomfortable discussing sexuality or sexual behaviors with another man. Male service providers can assure male clients that discussing sexuality issues with another man has nothing to do with a person’s sexual orientation. Assure the client that it is all right to discuss his reasons for his visit with you, and acknowledge that you have helped many other men.

ISSUE 3

A male client acts like he knows it all and does not need to learn from or listen to the service provider.

Cause

The client may feel anxiety or pressure that he is supposed to know everything about sex. He may want to mask this insecurity by pretending that he already knows everything about sex and sexual and reproductive health.

What a man might say

“You do not have to go through all that with a man like me. Believe me, I know all that stuff already. I can probably teach you a thing or two!”

Strategy

- Validate the client’s self-proclaimed knowledge about sex and sexual and reproductive health.
- Acknowledge the client’s good decision to come for counseling.
- Explain that it is your job to share important health information with all your clients.
- Shift the focus off the client, and discuss men in general.

Possible response

“I am sure you do know a lot about sex and sexual and reproductive health. You demonstrated that by coming here today to get help. But, as part of my job, I have to ask all my clients about how they protect themselves from sexually transmitted infections. So let us go through this, and I will just share with you some things that other men have asked about.”

Gender consideration

For female service providers, this issue might arise from a man’s discomfort with showing that he does not know something about sex in front of a woman. For male service providers, this issue might arise from a male client’s anxiety about being as knowledgeable as or more knowledgeable than other men. In either case, male and female service providers can follow the strategy listed above.

ISSUE 4

A male client becomes angry or threatening toward a service provider or his partner.

Cause

The client may be under a lot of stress. He may be reacting to news about an unintended pregnancy or an STI. He may be experiencing a difficult time in a romantic relationship. He may also be directing his anger or frustration toward the service provider.

(continued)

Some Strategies and Possible Responses for Addressing Issues That May Arise during Individual Counseling Sessions (continued)

What a man might say

- “Do not tell me what I am supposed to do!”
- “I cannot believe she did this to me. I am going to beat her when I see her.”

Strategy

- Allow the client to calm down and do not argue with him.
- Acknowledge and validate the client’s anger in a calm, empathetic manner.
- Assure the client that you are here to try to help him with his problem.
- Shift the focus off blaming others to a health treatment and prevention focus.
- If the client does not calm down, you might want to excuse yourself and possibly invite another staff member to accompany you when you return.

Possible response

“I see that you are angry about your STI diagnosis. It can be really hard to receive news like this. A lot of guys are initially angry when they hear about this and feel like they want to blame someone else. Unfortunately, people may pass STIs or become infected without even knowing it. It is often no one’s fault, and blaming others will not help. I want you to know that I am not here to tell you what to do, but to try to help you help yourself get healthy and stay healthy from now on. Would you like to continue talking in a little while when you are feeling better?”

Gender consideration

A threat of violence toward a service provider is rare and is probably no more likely to come from a male client than from a female client. Service providers concerned about their physical safety should refer to their facility’s security plan for addressing violent clients in general.

ISSUE 5

A male client makes flirtatious or sexual remarks to a service provider or sexualizes the CPI.

Cause

The client may be anxious or uncertain about appropriate behavior in an unfamiliar situation.

What a man might say

- “You must really like talking about sex a lot to do this job.”
- “You must really like men to talk about sex with them all day.”
- “Do you get turned on by talking to men about sex all day?”

Strategy

- Avoid making a flirtatious remark or joke in response.
- Validate your satisfaction with the work you do, and shift the focus to helping the client.

Possible response

“I do enjoy my job of counseling clients and helping them make good and healthy decisions. But we are here today to talk about you.”

Gender consideration

This issue may arise more often with female service providers and arises out of men’s discomfort and unfamiliarity with discussing sexuality in a professional setting. This is most likely a coping mechanism for men and is not necessarily based on a client’s sexual interest in a service provider.

The GATHER Approach

The GATHER approach is an accepted and widely used technique in counseling. The acronym “GATHER” stands for the steps of the approach: greet, ask/assess, tell, help, explain, and return/refer. Initially developed for family planning counseling, this approach has been adapted for counseling in the broader context of sexual and reproductive health because it is systematic and has already been proven to be effective.

When carried out in logical sequence, these steps systematize the counseling process. By systematizing the counseling process, service providers can make more efficient use of their time and efforts. Following these steps also enables providers to ensure that all essential parts that need to be presented and discussed are covered. In addition, the GATHER approach prevents providers from presenting an excessive volume of information that may leave clients confused.

GATHER is meant to be flexible. The application of particular steps and the tasks of each step depend on the assessed needs and concerns of the client. If a particular step is not relevant in some counseling situations, it can be skipped. GATHER simply provides an approach to make sure that service providers and clients discuss the key questions and issues during a counseling session.

In some countries, variations of GATHER or other counseling approaches are used. These approaches usually incorporate the most important elements of good communication with clients, such as assessing their needs and concerns and giving them the information they need. If other counseling or communication approaches are used, it is not necessary to use the GATHER approach. Once again, however, service providers must carefully adapt these approaches to allow for effective communication with clients. This means making sure that the necessary issues are discussed in order to meet the clients’ sexual and reproductive health needs.

The GATHER Approach

Step/Purpose	Actions to Take	Important Points
<p>Greet <i>To establish a rapport with the client</i></p>	<ul style="list-style-type: none"> • Welcome the client. • Introduce yourself. • Meet in a comfortable, private place. • Offer the client a seat. • Assure the client that everything you discuss will be kept confidential. • Express caring, interest, and acceptance through words and gestures throughout the session. • Explain what to expect. 	<ul style="list-style-type: none"> • Determine the purpose of the client's visit.
<p>Ask/Assess <i>To assess the client's sexual and reproductive health needs</i></p>	<ul style="list-style-type: none"> • Ask the client why he has come to the health care facility. • Determine what decisions or actions the client needs or wants to make or take during this visit. • Obtain the client's personal data, including medical and sexual history. • Assess the client's sexual and reproductive needs, feelings, and opinions. • Ask the client what he already knows about his situation. • Assess the risk factors for the client's specific sexual and reproductive health concern. 	<ul style="list-style-type: none"> • Encourage the client to do most of the talking. • Ask mostly open-ended questions. • Pay attention to what the client says, <i>how</i> he says it, and follow up with more questions. • Put yourself in the client's shoes without expressing criticism or judgment. • Ask about the client's feelings. • Use appropriate job aids and information, education, and communication (IEC) materials. • Explain to the client that risk assessment for reproductive tract infections (RTIs), STIs, and HIV/AIDS is routinely done at the facility.
<p>Tell <i>To provide information based on the client's sexual and reproductive health needs and knowledge</i></p>	<ul style="list-style-type: none"> • Start the discussion with the client's preference or most urgent need. • Give information relevant to the client's decision. • Ask the client if he understands the information. • Ask the client if he has any questions. • Tell the client about the risks for contracting STIs and the behaviors that can help prevent transmitting them. 	<ul style="list-style-type: none"> • Tailor the information to the client's need, knowledge, and personal situation. • Use words familiar to the client. • Avoid "information overload"—fill in the gaps in the client's knowledge and correct any misconceptions but do not provide more information than you think he wants or needs. • Use IEC materials.

(continued)

The GATHER Approach (continued)

Step/Purpose	Actions to Take	Important Points
<p>Help <i>To help the client make decisions to meet his specific sexual and reproductive health needs, and to help the client develop the skills needed to carry out the decisions</i></p>	<ul style="list-style-type: none"> • Let the client know that the decisions are his to make. • Help the client identify options. • Assist the client in making decisions that are realistic to carry out, based on their social context. • Ask the client to state his decisions, and then reflect the decisions to confirm it. • Help the client anticipate both the positive and negative consequences of his decisions. • Help the client identify possible barriers to carrying out his decisions. • Help the client identify the skills needed to overcome those barriers, such as partner communication and negotiation and condom use skills. • Help the client develop the skills needed through role plays, if applicable. 	<p>For a client who decides not to use the recommended treatment or management:</p> <ul style="list-style-type: none"> • Discuss the potential complications and consequences if the condition is not treated. • Offer your services if the client decides to use the services later.
<p>Explain <i>To explain the relevant management of the client's specific sexual and reproductive health needs, and the steps for carrying out his decisions</i></p>	<ul style="list-style-type: none"> • Explain the management and procedure related to the specific reproductive health service the client needs. • Describe the warning signs or symptoms that indicate that the client should seek treatment, and explain where to go if these occur. • Provide written instructions and review them with the client. • Confirm the client's understanding by asking him to repeat the instructions and warning signs. • Ask the client if he has any questions. • Provide services if appropriate. 	<p>The difference between the “Tell” and the “Explain” steps:</p> <p>For family planning concerns, information regarding methods appropriate to the client's reproductive intentions, knowledge, and situation is given in the “Tell” step, so that he can make a voluntary, informed choice.</p> <p>In the “Explain” step, details on how to use the one method chosen are provided.</p> <p>For other reproductive health concerns, information that will help the client realize the importance of complying with the recommended screening, diagnostic, or treatment procedure is give in the “Tell” step.</p> <p>In the “Explain” step, relevant details of the specific management and procedures (screening, diagnostic, or treatment procedure) are further explained, as appropriate.</p>

(continued)

The GATHER Approach (continued)

Step/Purpose	Actions to Take	Important Points
Return/Refer <i>To address the client's additional or future sexual and reproductive health needs</i>	<ul style="list-style-type: none"> • Schedule the client's next visit, if needed. • Invite the client to come back at any time, for any reason. • Inform the client about other services available at the site. • Refer the client for any services that are not provided at the site. • Thank the client for coming. 	<ul style="list-style-type: none"> • Ensure that the client knows exactly where to go for services he needs at the site. • Check that the client knows where to go for services he needs that are not offered at the site.

Sources: Rinehart, Rudy, & Drennan, 1998; EngenderHealth, 2001.

Role Plays

Many service providers find it helpful to review examples of counseling sessions that use the GATHER approach. The following two role plays provide examples of how service providers can use GATHER when talking with men about STIs and sexual dysfunction. The role plays also indicate the importance of using counseling sessions to discuss other reproductive health issues, such as the prevention of STIs, even though they are not the client's primary concern and the reason why he came to the health care facility.

The term in the parentheses—e.g., **(GREET)**—indicates the GATHER step or combination of steps that the service provider is using when communicating with the client and illustrates that the various steps do not have to be followed rigidly.

Male Client Seeking STI Services

Service provider: Hi. Welcome to the men's clinic. Please have a seat. My name is Thembi, and I will be providing you with counseling services today. Counseling is a service that we offer all of our male and female clients. It gives you an opportunity to talk about any health issues that you may be concerned about. All of our counseling is confidential, so anything you discuss with me will not leave this room. Do you have any questions so far? **(GREET)**

Client: No.

Service provider: Okay. Great. So tell me why you made a decision to come here today. **(ASK)**

Client: Well, something is not right.

Service provider: Okay. Will you tell me a little more about what is concerning you? **(ASK)**

Client: I have been having some pain when I urinate.

Service provider: How long have you been experiencing this? **(ASK)**

Client: About a week.

Service provider: What do you think is causing this? **(ASK)**

Client: I do not know.

Service provider: Well, sometimes when men have painful urination, it might be caused by a sexually transmitted infection, or an STI. Have you had any discharge coming from the top of your penis? **(ASSESS)**

Client: Well, actually yes, I have had some white stuff coming out down there.

Service provider: I see. I would like to ask you some sensitive questions to learn more about your possible risk for STIs. Is that okay? **(ASK/ASSESS)**

Client: Sure.

Service provider: Great. Have you engaged in sexual activity within the past few months? **(ASK/ASSESS)**

Client: Yes.

Service provider: And how many sexual partners have you had over the past three months? **(ASK/ASSESS)**

Client: Oh, about five women.

Service provider: Did you ever engage in penile-vaginal, anal, or oral sex without using a condom? **(ASK/ASSESS)**

Client: I do not use condoms.

Service provider: Okay. Thanks for sharing that. It sounds like you are at risk for STIs, so that is probably what is causing your symptoms. In a little while, the doctor will examine you to see if that is the case. It sounds like you probably already know a lot about STIs, but let me just provide some information anyway. STIs are actually quite common. Many diseases, like gonorrhea and chlamydia, have symptoms similar to what you are describing. Other STIs have other symptoms, like itching or irritation of the genitals, sores or bumps on the genitals, and rashes. Sometimes people get STIs and show no signs or symptoms at all. So it is very likely that the person who passed on the STI to you had no idea that she was infected.

It is also important to remember that some STIs can be cured and others cannot. The diseases that cause the symptoms you are describing can be cured by taking pills or receiving a shot. Other STIs, like HIV infection and genital herpes, cannot be cured. HIV infection is

particularly important to prevent because it cannot be cured and it usually results in death from AIDS.

I know that is a lot of information. Do you have any questions? **(TELL)**

Client: Did you say that my symptoms *can* be cured?

Service provider: Yes, it sounds like you have gonorrhea or chlamydia, which can be cured. When the doctor examines you, he will be able to tell you if that is what is causing your symptoms. He will also ask you if you want to be tested for any other STIs that may or may not show symptoms, like syphilis and HIV infection. **(TELL)**

In the meantime, let us talk about ways to protect yourself. Tell me what you are doing now to protect yourself from STIs. **(HELP)**

Client: Nothing.

Service provider: What keeps you from using condoms? **(HELP)**

Client: I do not like the way they feel.

Service provider: Yes, many men agree with you. Condoms can reduce sexual pleasure, but they can also prevent the type of pain you are experiencing right now. Condoms are highly effective in preventing STIs, including HIV infection. So their benefits greatly outweigh their drawbacks. Also, some men actually like using condoms because it helps them last longer when having sex. Do you think you would be willing to try using condoms the next time you have sex? **(HELP)**

Client: Yeah, I guess.

Service provider: Do you think your partners would be willing to use condoms? **(HELP)**

Client: Sure. They sometimes even ask me to, but I try to talk them out of it. Maybe I should start using them.

Service provider: Great. You will be glad you did. I will give you a bag of condoms to take home with you. Now I am sure you already know how to put on a condom correctly, but let me just review a few key points on what some men struggle with. Okay? **(HELP)**

Client: Sure.

Service provider: Here is a condom. One mistake that many men make is that they do not store condoms properly. Condoms should always be kept in a cool, dry place. A man can carry a condom in his pocket or wallet, but he should remove it if he does not use it. **(EXPLAIN)**

Now let me demonstrate how to put on a condom correctly. I will use this model. (The service provider demonstrates how to put on a condom correctly using a penis model.)

Do you have any other things you would like to discuss today?

Client: No, that is all for now.

Service provider: Okay. Thanks for coming to talk with me today. In a minute, the doctor will call you in for an examination. If it turns out you have an STI, he will talk to you about informing your sexual partners. This is really important because they need to get treated as well. They probably have no idea that they are infected. It is very common for men to show symptoms, but women often show no signs of an STI. Also, the doctor will ask if you want to take a screening test for HIV infection and syphilis. If you decide not to take these tests today, you can always come another time and take them. I will give you this brochure on STIs and this flyer that lists all of the men's sexual and reproductive health services that we offer. We are open six days a week. We are usually open from 9 to 5, and we also have an evening clinic on Thursday nights. Please come by anytime, even if you just have a simple question. **(RETURN)**

Client: Thanks, I will. You guys are very nice. I thought you were going to yell at me for catching a disease.

Service provider: Well, we are happy you came to see us. Nobody should be blamed for catching an STI, but we do want to help make sure that you do not have to go through this experience again. Have a good day.

Male Client Seeking Counseling on Sexual Dysfunction

Service provider: Hi. Welcome to the men's clinic. Please have a seat. My name is Ram, and I will be providing you with counseling services today. Counseling is a service that we offer all of our male and female clients. It gives you an opportunity to talk about any health issues that you may be concerned about. All of our counseling is confidential, so anything you discuss with me will not leave this room. Do you have any questions so far? **(GREET)**

Client: No.

Service provider: Okay. Great. So tell me why you made a decision to come here today. **(ASK)**

Client: Well, something is not right.

Service provider: Okay. Will you tell me a little more about what is concerning you? **(ASK)**

Client: I am having problems with sex.

Service provider: I see. What kinds of problems are you experiencing? **(ASK)**

Client: Well, sometimes I cannot perform sexually.

Service provider: This is actually very common. Many men come to me with this problem every week. How often do you experience this? **(ASK)**

Client: Well, I have had this problem from time to time, but it seems most serious with my current girlfriend.

Service provider: I see. And how long have you been experiencing these problems with your current girlfriend? **(ASK)**

Client: For about a month.

Service provider: Do you have problems performing sexually with her every time? **(ASK)**

Client: Yes. In fact, we have never had sex because I always lose my erection right before.

Service provider: I see. This is also fairly common. Tell me, are you able to sustain an erection before you try to have sexual intercourse with your partner? **(ASK)**

Client: Yes, I usually start out having an erection.

Service provider: And when you have an erection, are you able to maintain the erection during other sexual acts, like masturbation and oral sex? **(ASK)**

Client: Yes. In fact, my girlfriend often gives me oral sex without a problem.

Service provider: Well, that is encouraging news. It suggests that your problem may be psychological rather than physical. Tell me, do you ever get worried about maintaining an erection before trying to have sexual intercourse? **(ASSESS)**

Client: Yes, all the time!

Service provider: Sure. A lot of guys do. The stress that you are experiencing before having sex is probably one of the things that is causing your problems. Stress and anxiety often make it difficult for a man to achieve or maintain an erection. So, in fact, the more you worry about your problem, the worse it will get. The good news is that most men find ways to overcome this. A lot of times, men talk with their partners and agree that they will not have sexual intercourse on a particular night. That often allows the man to avoid the stress and simply enjoy himself by doing other sexual activities. As time goes on, the man finds that he is having erections on a normal basis and no longer worries about maintaining an erection. At this time, he begins to have sexual intercourse.

Do you think you could try this with your partner? **(TELL)**

Client: Sure. I guess.

Service provider: She may be very excited to hear that there is something that you can do as a couple to help the problem that the two of you are experiencing. Now let me ask another question. Do you drink alcohol or take any medications? **(ASK/ASSESS)**

Client: Sure. I drink.

Service provider: How much do you drink? **(ASK)**

Client: Well, I have been drinking a lot lately at night because of this sexual problem and because I have not been able to find a job.

Service provider: I see. Well, your consumption of alcohol is probably contributing to your problem of maintaining an erection. Alcohol lowers a man's sex drive and can lead to sexual dysfunction. Do you think you could try to stop drinking for awhile and see if your problem improves? **(TELL)**

Client: Sure.

Service provider: Great. Also, the stress from looking for employment can contribute to sexual dysfunction. Any type of stress affects a man's ability to perform. **(TELL)**

Client: Wow, I did not know that.

Service provider: Sure. Now you can see why so many men have these problems. So try out some of these things we have discussed: setting limits on your sexual activity, limiting your alcohol intake, and trying to avoid stress. Things will probably improve dramatically. If not, please come back to me and we can discuss this some more. Now, let me ask you a few other questions that we ask all men who come here. **(HELP)**

Tell me what you are doing now to protect yourself from STIs and unintended pregnancy? **(ASK)**

Client: Well, I sometimes use condoms. My girlfriend uses birth control pills.

Service provider: Great. Condoms are very effective in preventing STIs. And using pills with condoms provides added protection from pregnancy. What keeps you from using condoms all of the time? **(ASK)**

Client: Sometimes I lose my erection when I try to put a condom on. So it is just easier not to use one.

Service provider: A lot of men experience this. It is really important that you use a condom every time you have sex. There are some things you can do to make condoms more pleasurable. You could ask your partner to put on the condom, which may help you maintain your erection. You could also put a lubricant on the inside of the condom. This will make it feel better and help you maintain your erection. Just make sure that the lubricant does not contain any oil. Things like lotion and baby oil can cause a condom to break.

Now I know that you know this, but let me demonstrate how to put on a condom correctly. I will use this model. (The service provider demonstrates how to put on a condom correctly using a penis model.)

Do you have any other things you would like to discuss today? **(TELL/HELP)**

Client: No. That is all.

Service provider: Okay. Thanks for coming to talk with me today. We are open six days a week. We are usually open from 9 to 5, and we have an evening clinic on Thursday nights. Please come by anytime, even if you just have a simple question. Here is a list of the men's sexual and reproductive health services we provide. You can see that we offer family planning, STI diagnosis and treatment, infertility services, and counseling on a variety of issues. **(RETURN)**

Client: Thanks. Maybe I will come see you again.

Service provider: Great. And tell your friends about our services as well.

Client: I will. 'Bye.

GATHER Counseling Reference Cards

Many service providers find it helpful to have a set of reference cards to refer to when providing counseling. The cards on the following pages were developed to serve as a resource for providers who counsel men on three important sexual and reproductive health issues: STIs, sexual dysfunction, and family planning. The cards, which are based on the GATHER approach to counseling, list key questions that service providers may ask and necessary information that providers should convey. The cards should not be viewed as a script, but rather a resource to use to help ensure that the essential issues and facts are shared during a counseling session.

Service providers may want to make multiple copies of these cards and distribute them to others who offer counseling services. If possible, sites may want to consider laminating the copies of the cards so that they will last a long time.

GATHER Counseling Reference Card: STIs

This card contains the key information about STI prevention that should be discussed with every male client. Ideally, the information should be integrated to address the total sexual and reproductive health needs of the client.

***Greet:* To establish a rapport with the client**

- Welcome the client.
- Introduce yourself.
- Meet in a comfortable, private place.
- Express caring, interest, and acceptance through words and gestures throughout the session.
- Assure the client that everything you discuss will be kept confidential.
- Explain what to expect.

***Ask/Assess:* To assess the client's STI risks and needs**

- “Why did you come here today?”
- “What are you doing to protect yourself from STIs?”
- “How many sexual partners have you had in the past three months?”
- “Have you ever engaged in unprotected penile-vaginal, anal, or oral sex?”
- “Do you ever pay for sex?”

***Tell:* To provide information about STIs based on the client's sexual and reproductive health needs and knowledge**

- Risk for STIs
 - Vaginal and anal sex without a condom carry a high risk of transmission.
 - Oral sex without a condom or barrier carries a lower risk but is not risk-free.
- Safer Sex

The following activities are ways to prevent most STIs:

 - Having sex with only an uninfected partner who has sex only with you.
 - If this is not possible or if you do not know if your partner is infected:
 - For penile-vaginal and anal sex, use condoms each and every time.
 - For oral sex, use a condom over the penis or use plastic wrap or a condom cut open over the vagina or anus.
 - Engage in other forms of sexual activity, such as using your hand to stimulate your partner.
 - Remember that sores and warts can be present in areas that are not protected by a condom, so transmission can occur even with condom use.
- Symptoms of STIs

Many people who have STIs have no symptoms. When symptoms appear, they may include:

 - Abnormal discharge from the vagina or penis
 - Pain or burning with urination
 - Sores or bumps on the genitals
 - Rashes, including rashes on the palms of hands and soles of feet
 - In women, pelvic pain (pain below the belly button)

(continued)

GATHER Counseling Reference Card: STIs (continued)

Help: To help the client make decisions about preventing STIs to meet his specific sexual and reproductive health needs, and to help the client develop the skills needed to carry out the decisions

- “What will you do to reduce your risk for STIs in the future?”
- “How could you begin talking to your partner about condom use?”
- “What would be some benefits of condom use?”

Explain: To explain the relevant management of STIs, and the steps for preventing future infections

- Explain the management of and procedure for any necessary STI treatment.
- Explain the importance of abstinence until any necessary STI treatment is completed.
- Explain the importance of partners getting tested.
- Demonstrate how to put on a condom correctly.

Refer/Return: To address the client’s additional or future sexual and reproductive health needs

- Schedule the client’s next visit, if needed.
- Invite the client to come back at any time, for any reason.
- Inform the client about other services available at the site.
- Refer the client for any services that are not provided at the site.
- Thank the client for coming.

GATHER Counseling Reference Card: Sexual Dysfunction

This card contains the key information about sexual dysfunction that should be discussed with every male client. Ideally, the information should be integrated to address the total sexual and reproductive health needs of the client.

***Greet:* To establish a rapport with the client**

- Welcome the client.
- Introduce yourself.
- Meet in a comfortable, private place.
- Express caring, interest, and acceptance through words and gestures throughout the session.
- Assure the client that everything you discuss will be kept confidential.
- Explain what to expect.

***Ask/Assess:* To assess the client's sexual dysfunction needs**

- “Why did you come here today?”
- “Are you satisfied with your sex life? Can you tell me why you are dissatisfied?”
- “How often do you experience problems sustaining or maintaining an erection?”
- “How often do you experience premature ejaculation?”
- “Do you use drugs or alcohol?”
- “Do you have any medical conditions?”
- “Are you on any medications?”
- “Do you ever experience erections during sexual activity? Do you ever wake up with an erection?”

***Tell:* To provide information about sexual dysfunction based on the client's sexual and reproductive health needs and knowledge**

- *Erectile Dysfunction*
 - Psychological causes include:
 - Depression
 - Performance anxiety
 - Stress
 - Physical causes include:
 - Alcoholism
 - Certain medications, such as antidepressants
 - Diabetes
 - Heavy alcohol and/or drug use
 - Injuries
 - Testosterone deficiency
 - Vascular diseases
 - Identifying the cause of sexual dysfunction:
 - If a man is able to achieve an erection in his sleep or during certain types of sexual activity, then the cause is most likely psychological.
 - Eliminating the use of drugs, medication, and alcohol can help determine if this is the source of a man's erectile dysfunction.

(continued)

GATHER Counseling Reference Card: Sexual Dysfunction (continued)

- *Premature Ejaculation*
 - Causes include:
 - Conditioned rapid response to sexual stimuli
 - Low levels of sexual arousal
 - Missing internal cues
 - Performance anxiety

Help: To help the client make decisions about addressing sexual dysfunction to meet his specific sexual and reproductive health needs, and to help the client develop the skills needed to carry out the decisions

- “How could you talk with your sexual partner about this?”
- “How could you make condom use more pleasurable so that it does not interfere with your ability to maintain an erection?”

Explain: To explain the relevant management of sexual dysfunction, and the steps for carrying out his decisions

- *Erectile Dysfunction*
 - If necessary, explain the management of and procedure for any medical treatment for sexual dysfunction.
 - Limit alcohol intake.
 - Reduce emphasis on penile-vaginal sex during sexual activity to limit performance anxiety.
 - Try to eliminate stress.
- *Premature Ejaculation*
 - Masturbate before intercourse.
 - Use the squeeze technique (gently squeeze the tip of the penis when orgasm is near).
 - Use the start/stop technique (stop and relax until the ejaculatory feeling subsides).
 - Wear a condom.

Refer/Return: To address the client’s additional or future sexual and reproductive health needs

- Schedule the client’s next visit, if needed.
- Invite the client to come back at any time, for any reason.
- Inform the client about other services available at the site.
- Refer the client for any services that are not provided at the site.
- Thank the client for coming.

GATHER Counseling Reference Card: Family Planning

This card contains the key information about family planning that should be discussed with every male client. Ideally, the information should be integrated to address the total sexual and reproductive health needs of the client.

***Greet:* To establish a rapport with the client**

- Welcome the client.
- Introduce yourself.
- Meet in a comfortable, private place.
- Express caring, interest, and acceptance through words and gestures throughout the session.
- Assure the client that everything you discuss will be kept confidential.
- Explain what to expect.

***Ask/Assess:* To assess the client's family planning needs**

- “Why did you come here today?”
- “What are your plans for having or delaying children?”
- Obtain a basic history including age, number of living children, sex of children, and marital status.
- Assess what the client knows about contraceptive methods.
- Determine if the client has already decided on a contraceptive method, and if so, which one.
- Help the client assess his risk for STIs.

***Tell:* To provide information about family planning based on the client's sexual and reproductive health needs and knowledge**

- Focus on contraceptive methods that require men's active cooperation; these include condoms, vasectomy, withdrawal, and natural family planning. Discuss the following points:
 - What the method is
 - How it works
 - How effective it is
 - Advantages
 - Disadvantages
 - Possible side effects
 - STI protection
- Use method samples and/or drawings.

***Help:* To help the client make decisions about family planning to meet his specific sexual and reproductive health needs, and to help the client develop the skills needed to carry out the decisions**

- Ask the client which family planning method he would like to use.
- Ask the client to repeat key information, to confirm his understanding.
- Help the client determine his risk for STIs and whether or not he needs to use dual protection.

(continued)

GATHER Counseling Reference Card: Family Planning (continued)

Explain: To explain the relevant management of family planning, and the steps for carrying out his decisions

- Explain how to use the method.
- Ask the client to repeat the instructions, and listen carefully to make sure he understands.
- If the client wants a vasectomy, ensure that his decision is voluntary, informed, and well considered.
- Demonstrate how to use a condom correctly for dual protection.

Refer/Return: To address the client's additional or future sexual and reproductive health needs

- Schedule the client's next visit, if needed.
- Invite the client to come back at any time, for any reason.
- Inform the client about other services available at the site.
- Refer the client for any services that are not provided at the site.
- Thank the client for coming.

(See the diagrams of internal and external parts of the male reproductive system to be used during counseling sessions on pages 3.6 and 3.7.)

Working with Couples

A comprehensive approach to involving men in sexual and reproductive health programs goes beyond the program activities that are traditionally associated with men's services (e.g., STI testing and treatment) and moves toward embracing men as partners in and advocates for a wide range of reproductive health issues—for their own sakes and for their partners' sake. This type of approach includes working with men and their partners as a couple, rather than focusing solely on the men's individual needs.

Opportunities for Men's Participation

Opportunities for men to join their partners for sexual and reproductive health counseling fall into five primary spheres:

- Family planning decision making
- STI/HIV prevention
- Safe motherhood/antenatal care
- Postabortion care
- Violence prevention

Family Planning Decision Making

This involves:

- Encouraging men to support their partner's use of contraception
- Educating couples about male contraceptive methods that require men's active participation
- Motivating men to consider using contraceptive methods that require their participation, such as condoms, withdrawal, natural family planning, and vasectomy
- Discussing with couples both the spacing and the number of pregnancies they desire

Couples who disagree about family planning use make up a substantial share of couples with unmet contraceptive needs. The female partners in these couples are also less likely to use contraception effectively. Couples who discuss family planning are more likely to use contraception, to use it effectively, and to have fewer unintended pregnancies (Drennan, 1998).

STI/HIV Prevention

This involves:

- Generating awareness about men's role in protecting themselves and their partners from STIs, including HIV infection
- Educating couples about the correct and consistent use of condoms
- Motivating men to get tested and treated for STIs

Involving men in prevention is crucial to addressing the rising rates for STIs, particularly HIV infection, around the world. A couples approach to testing and treatment can address the potential for treatment noncompliance, reinfection, and relationship violence.

Safe Motherhood/Antenatal Care

This involves:

- Educating men about the importance of bringing their partner to a health facility for antenatal care

- Teaching couples how to recognize an obstetrical emergency
- Showing men what they can do to support their partner's health both during pregnancy and after delivery (postpartum care)

Men's support is often critical to birth spacing, access to adequate nutrition, skilled care during delivery, and avoiding delays in seeking care. Men are often more receptive to considering their role as a father immediately before or after a birth and can be encouraged to take more responsibility for the care and nurture of their children.

Postabortion Care

This involves:

- Educating men about their role in helping their partner avoid complications of abortion
- Discussing contraceptive methods with couples in order to prevent future unintended pregnancies

Joint counseling of couples can significantly increase the use of a modern method of contraception following an abortion (Ringheim, 2001).

Violence Prevention

Although violence prevention is a "couple's issue," discussions related to violence prevention should take place in individual settings where a provider is meeting with a male client.

This involves:

- Educating men about the harm caused by traditional male roles that encourage or condone violence against women
- Educating men about the link of violence to their own, their partner's, and their family's health
- Educating men about violence prevention, including sexual abuse prevention

Ending the abuse and mistreatment of women requires the support and involvement of men. Men can play powerful roles in stopping individual acts of violence against women.

Men can also be instrumental in ending abusive traditional practices, such as female genital mutilation (Kiragu, 1995).

Key Themes for Couples Counseling

Couples, or spousal, communication holds both promise and risk for making healthy, responsible decisions. Although couples communication can encourage shared decision making, gender equity, effective use of contraceptives, and agreement about desired family size, there may be times when communication between partners is not desirable. Service providers need to carefully assess the potential risks of meeting with couples and to monitor their interaction for possible unintended outcomes. If it all possible, providers should meet individually with one or both partners before a couples meeting. Protocols that require this type of meeting can be a useful tool for providers to explain the need for an individual

meeting to a reluctant or resistant couple or client. In addition, during this individual meeting, service providers can complete some screening for relationship violence.

Service providers should be aware of the following key issues that may arise during couples counseling:

- Power/gender dynamics
- Client confidentiality
- Informed choice

Power/Gender Dynamics

Power and gender dynamics can be very influential during counseling sessions with couples. So it is essential for service providers to understand their own biases either toward or in favor of men and to recognize any power dynamics that might be occurring between a couple during couples counseling sessions. For example, if a provider cannot discuss certain issues with a couple during counseling, he or she might need to decide to discuss these issues separately with the clients.

Potential Provider Bias against Men. Service providers who make men feel uncomfortable or unwelcome will likely reinforce their distrust of sexual and reproductive health services, as well as the men's resistance to their partner accessing these services.

Potential Provider Bias toward Men. There is evidence that when men are counseled with their partner, they get more than their share of attention. Service providers may reinforce the idea that the man has the authority or is the decision maker and may unintentionally ignore his partner's input during the counseling session.

Cultural or Societal Factors. Service providers must recognize the cultural or religious taboos about men and women discussing sex that exist in their setting. They must also work to promote more equitable communication and decision making within this setting.

Gender Dynamics within the Couples Relationship. In situations in which one partner dominates the other, service providers need to encourage the "weaker" partner to express his or her concerns and ensure that they address both partners' issues. (In many cultures, men are usually the decision makers and the "weaker partner" in a heterosexual couple is usually the woman.) Service providers can explore relationship power dynamics to screen for possible relationship violence, but they need to be careful not to assume the presence of violence based on a communication pattern (male dominance) that may simply be a reflection of cultural norms.

Client Confidentiality

Client confidentiality includes undisclosed information between partners (based on a service provider having met individually with one or both partners), as well as undisclosed contraceptive use, STIs, or multiple partners. It is important for the service provider not to violate either partner's right to privacy and confidentiality, even if the provider thinks it is in the best interest of one or the other of the partners. During individual meetings, the service provider must assess the risk of encouraging a client to disclose such information to his or her partner.

Informed Choice

Informed choice is a voluntary, well-considered decision that a client makes on the basis of options, information, and understanding. In a counseling setting, a male client or a couple should make a free, informed decision about whether or not to receive reproductive health services, and, if so, which treatments or contraceptive methods to use. It is important for the provider to be aware of his or her bias during a counseling session to ensure that the male client or the couple makes an informed choice.

Provider Bias: Because service providers may be biased toward a certain contraceptive method or assume a need for disease prevention, they may limit the information and choices that they offer clients and their partners. Assumptions about relationship status, partners, and sexual orientation can all contribute to provider bias and circumvent a client's and his partner's ability to make an informed choice about his or her sexual and reproductive health care.

Client Bias: One partner may reject a certain contraceptive method or a need for disease prevention and treatment, thereby preventing the service provider from giving the couple complete information and options. Providers need to explore potential client bias while ensuring that they offer the couple thorough, accurate information and options. One partner may have misperceptions about the attitudes held by the other partner, which prevents him or her from considering all the possible options offered. Service providers can help bridge this gap in understanding.

Techniques and Tips for Couples Counseling Sessions

Service providers can make a couple feel comfortable during a counseling session various ways. These include the following techniques and tips, which help create a positive environment.

If at all possible, service providers should meet with each partner individually. Depending on the issue, it may be better for service providers to meet with the partners separately rather than together. In some situations, it is not necessarily better for service providers to meet the partners together.

Service providers need to:

- Set the tone of the session by explaining its basic protocols and limitations of the counseling session (e.g., it is not a therapeutic session)
- Actively elicit information from both partners
- Acknowledge the importance of couples working together

Responding to Issues That May Arise during Couples Counseling Sessions

As with individual counseling sessions, issues, or themes, may present themselves in relation to men's participation within couples counseling sessions. The chart on page 4.29,

which continues on pages 4.30–4.32, outlines the issues, underlying causes, and strategies and suggestions for responding to couples during counseling sessions. Service providers may need to adapt these responses in order to complement their own style; their intuition, which is based on their specific experiences; and their cultural context. In certain situations, the service provider’s gender may also be a factor; possible responses are offered for these situations as well.

Some Strategies and Possible Responses for Addressing Issues That May Arise during Couples Counseling Sessions

ISSUE 1

During the session with a couple, the man may do all or most of the talking. He may interrupt his partner, always speak first, or speak on his partner’s behalf.

Cause

- The couple may be exhibiting the culturally accepted patterns of communication and decision making for men and women.
- The man may be consciously exerting his power in the relationship, and the woman may be ceding power to avoid conflict.
- The man may be trying to demonstrate that he is competent and knows everything about the issue or situation.

What a couple might say

- “We are here because. . . .”
- “She does not understand the problem.”

Strategy

- Start with the cultural norms of the setting: acknowledge the man’s interest and role.
- Explain from the beginning of the session that you will need to get information from both partners—that, in fact, this is required.
- Encourage the woman to talk by directing open-ended questions to her that cannot be answered with a “Yes” or “No.”
- If possible, use any information that the woman shares to admire the man’s actions. He may be afraid that when his partner talks about him, the service provider will agree with her; he will be more likely to support her talking if he gets positive reinforcement based on her comments.

Possible response

- “I can tell you are very interested in this information (or situation), but I also need to hear from your partner.”
- “You may be able to give me all the answers to my questions, but I am required to get responses from both partners during this meeting.”

Gender consideration

- When male service providers counsel couples, it is important for them to be aware of the potential of the “man-to-man” interaction. This is especially true in cultures in which men make more relationship decisions than women.
- When male service providers try to draw out a female partner, they need to be careful to keep the approach clearly professional.

(continued)

Some Strategies and Possible Responses for Addressing Issues That May Arise during Couples Counseling Sessions (continued)

ISSUE 2

The man is hesitant to share information or seems disinterested during the session, and lets his partner do all the talking.

Cause

- The man may be hesitant to appear as if he does not understand the information he is getting during the session.
- The man may be unaware of his partner's contraceptive practices.
- The man may perceive this to be a counseling session "for the woman" and thinks that he does not have anything to learn.
- The service provider may be asking questions that are hard for the man to answer, such as "How do you feel about this contraceptive method?"

What a couple might say

- "I do not know."
- "Everything is fine."
- "I do not really have any problems."
- "This is really her job."

Strategy

- Encourage the man to share his ideas about the situation instead of about himself. Offer him a list of choices.
- Do not interpret the man's lack of sharing as disinterest. Do not let his partner answer for him; try to actively draw him out.
- Emphasize that the man's involvement is necessary for his partner's health.
- Rephrase questions more concretely—e.g., "What do you think would be good about using this contraceptive method?" instead of "How do you feel about your partner using this contraceptive method?"

Possible response

- "I appreciate that you care for your partner and show it by coming in with her today. Your support is very important to her health."
- "A lot of men wonder how all this relates to them. What questions do you have about your role in . . . ?"
- "Some other men have had these questions when they came in with their partner. [List some questions.] Which of these questions would you like more information about?"

Gender consideration

When the service provider is female, a man may feel as if this is "woman's talk" or want to avoid looking "bad" in front of two women. Also, the service provider may have a prior professional relationship with the woman; if so, the provider needs to quickly address this and direct attention to the man's participation.

ISSUE 3

One partner reveals information during the session that is a surprise to the other partner.

Cause

- One partner is using the opportunity or safety of having a third party present to reveal the information.
- The partners may never have talked about this information before and made assumptions about their partner's knowledge or attitudes.

(continued)

Some Strategies and Possible Responses for Addressing Issues That May Arise during Couples Counseling Sessions (continued)

What a couple might say

- “Why did you not tell me that before?”
- “I assumed you did not want me to talk to you about that.”
- “I cannot believe you hid this from me.”
- “I had a former partner who used this method, and it worked for her.”

Strategy

- Focus the discussion on the reason(s) the man came in with his partner to the health care facility.
- Frame the discussion as a positive opportunity for the man to support his partner.
- Assure the man that it is common for couples not to know everything about each other, and that while it can be hard to learn some things about your partner, the information they now have can help him make better decisions for his health and better support his partner’s health in the future.

Possible response

- “Many couples never talk about . . . [e.g., contraception, STIs, childbirth], so it is not uncommon for there to be misperceptions. Now that you know this about each other, you can take better care of your health and each other’s health.”
- “I know you want to do what is best for you and your partner. Having this information will help you do that.”
- “I know you will want to talk more about this later, but right now we can take care of this immediate issue [e.g., current contraceptive method, treatment decision, antenatal care].”

ISSUE 4

Partners disagree on the “plan of action” or need for information about, for example, contraception, child spacing, or treatment option.

Cause

- One partner may want more children to secure the relationship.
- One partner may not be revealing a condition or information that is relevant to the counseling situation—e.g., the man is supporting a second family; during antenatal care or delivery, the woman discovered that she is HIV-infected and might not have shared this information with her partner.
- The man may be acting on beliefs based on myths or misinformation about family planning or reproductive health.
- The man is acting on cultural/societal/religious beliefs that favor certain reproductive health behaviors [e.g., large families, virility, prohibition of contraception].

What a couple might say

- “We do not need to worry about ‘that.’”
- “That method of birth control is wrong [or “is a sin,” “does not work,” or “is only for prostitutes”].”
- “A man is supposed to decide how many children he has.”
- “That is her job. It is not really my concern.”

Strategy

- Affirm that it is not unusual for couples to disagree about reproductive health issues, but the man’s presence indicates that he wants to support his partner.

(continued)

Some Strategies and Possible Responses for Addressing Issues That May Arise during Couples Counseling Sessions (continued)

- Distinguish between short-term plans and long-term plans—e.g., what will work best “right now.” Give the man options for ways he can support short-term goals.
- Offer a compromise plan that meets short-term goals (e.g., use of a temporary contraceptive method instead of sterilization).
- Recognize cultural/societal/religious issues, and clarify any myths and misinformation that the man believes.

Possible response

- “I know you may not need this information, but I am required to give all the basic information on . . . [e.g., contraception, STIs], so please be patient while I explain this.”
- “Some men have been told that contraception does not work [or “contraception is the woman’s job” or “a man does not have a role in healthy pregnancy and childbirth”], but that old information caused lots of problems for women and men. You seem to be open to learning about new ideas and approaches that are healthier.”

ISSUE 5

The man verbally discounts his partner’s abilities or intentions or is discounted by his partner for his abilities and intentions during the session.

Cause

- Partners may be reinforcing stereotypes about abilities and attitudes based on gender—e.g., “Men do not really care about this stuff,” or “Women who talk about sex are promiscuous.”
- If the man verbally discounts his partner, he may feel threatened by coming into the health care facility, or by the combination of the service provider and his partner, and he may be trying to assert his abilities.

What a couple might say

- “She is so forgetful, she would never remember to take the pill.”
- “He only wants me to take the pill so he does not have to do anything.”

Strategy

- Affirm that the man can help break stereotypes through his support and actions.
- Point out that both partners must care about this decision/issue since they came to the counseling session together.
- Acknowledge that while there are certain stereotypes about men and women, it is clear by the partners’ commitment to come to the facility today that they want to break those stereotypes.
- Encourage the female partner to recognize that her partner’s coming to the facility is a sign of care and commitment.

Possible response

- “While it is true that some men do not think they should have to deal with birth control, your partner is showing that he wants to be more involved.”
- “Since you are here with your partner, what can you do to help her use her contraceptive method more effectively?”

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