Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning Counseling: A Training Manual

Volume 2 – Handouts

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ENGENDERHEALTH
Improving Women’s Health Worldwide
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PARTICIPANT HANDOUT: WHAT IS SEXUALITY?

SEXUALITY IS:
• It’s an expression of who we are.
• It involves the mind and the body.
• It’s shaped by our values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, and the ways we have been socialized.
• It’s influenced by social norms, culture and religion.
• It involves giving an receiving sexual pleasure, as well as enabling reproduction.
• It spans our lifetimes.

SEXUALITY INCLUDES:

Sex
• Refers to the biological characteristics that make us male or female (anatomical, physiological and genetic).
• It also refers to sexual activity, including sexual intercourse.

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

Sexual orientation
• **Heterosexuality**: erotic or romantic attraction to people of the opposite sex
• **Homosexuality**: erotic or romantic attraction to people of the same sex
• **Bisexuality**: erotic or romantic attraction to people of both sexes

Sexual identity
• Refers to how people view themselves sexually, which includes four main elements: (1) how a person identifies as male, female, masculine, feminine, or some combination (i.e., gender identity); (2) the individual’s sexual orientation; (3) gender roles; and (4) biological sex
**PARTICIPANT HANDOUT: SEXUAL AND REPRODUCTIVE HEALTH**

**Sexual Health**

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

The basic elements of sexual health include:
1. A sexual life free from disease, injury, violence, disability, unnecessary pain, or risk of death.
2. A sexual life free from fear, shame, guilt, and false beliefs about sexuality.
3. The capacity to enjoy and control one’s own sexuality and reproduction.

International Women’s Health Coalition

Sexual health is the integration of the somatic, emotional, intellectual and social aspects of the sexual being, in ways that are positively enriching and that enhance personality and communication, and thus the notion of sexual health implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relations, and not merely counseling care related to reproduction and sexually transmitted diseases.

International Planned Parenthood Federation

**Reproductive Health**

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice … and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems.

World Health Organization and International Planned Parenthood Federation

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*The definitions of reproductive health and sexual health in this document are those adopted in 1994 at the International Conference on Population and Development (ICPD) in Cairo, Egypt.*
Sexual and Reproductive Health

A sexual and reproductive health approach takes a broader, more comprehensive view of a woman’s health and takes into account the whole life cycle of health requirements in relation to sexuality and reproduction.

More than this, a sexual and reproductive health approach broadens the focus to include the sexuality needs of men and young people; it rejects an isolated quantitative approach in favor of an integrated and qualitative one; and it requires that those with concerns about sexuality and reproduction are involved in finding the solutions to those concerns. The aims are to ensure people’s ability to enjoy sexual relations without fear, and improve the quality of sexual relationships. In other words, it requires a fundamental change of attitudes on the part of those who can provide services.

International Planned Parenthood Federation

The term sexual and reproductive health can be used in various ways. It can refer to a) a state of health and well-being, b) types of services, or c) an “approach” to service delivery as follows:

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

b) Types of services:
- Pregnancy-related services (antenatal, postpartum, emergency obstetric care)
- HIV/STI prevention and services
- Family planning
- Post-abortion care
- Integrated services (e.g., family planning and HIV/STI prevention)

c) Approach to services:
- The way services are provided
- The issues that are taken into account or addressed when services are provided
- New ways of providing existing services
- The mentality and attitude behind the way that services are provided

Some examples of an “approach” to services:
- Holistic, integrated approach to service provision
- Focus on partner involvement and communication
- Sensitivity to gender issues
- Promoting awareness of sexuality
• Taking into account the context of peoples’ decision-making (e.g., gender power dynamics, poverty, domestic violence and other vulnerabilities)
• Incorporating a human rights perspective in counseling and other services;
• Fostering community involvement
Sexuality is an integral part of the personality of every human being. Its full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love.

Sexuality is constructed through the interaction between the individual and social structures. Full development of sexuality is essential for individual, interpersonal, and societal well being.

Sexual rights are universal human rights based on the inherent freedom, dignity, and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, the following sexual rights must be recognized, promoted, respected, and defended by all societies through all means. Sexual health is the result of an environment that recognizes, respects and exercises these sexual rights.

1. **The right to sexual freedom.** Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all forms of sexual coercion, exploitation, and abuse at any time and situations in life.

2. **The right to sexual autonomy, sexual integrity, and safety of the sexual body.** This right involves the ability to make autonomous decisions about one's sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture, mutilation and violence of any sort.

3. **The right to sexual privacy.** This involves the right for individual decisions and behaviors about intimacy as long as they do not intrude on the sexual rights of others.

4. **The right to sexual equality.** This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class, religion, or physical and emotional disability.

5. **The right to sexual pleasure.** Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual and spiritual well being.

6. **The right to emotional sexual expression.** Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality through communication, touch, emotional expression and love.

7. **The right to sexually associate freely.** This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associations.

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* Source: World Association of Sexology (WAS), Adopted in Hong Kong at the 14th World Congress of Sexology, August 26, 1999.
8. **The right to make free and responsible reproductive choices.** This encompasses the right to decide whether or not to have children, the number and spacing of children, and the right to full access to the means of fertility regulation.

9. **The right to sexual information based upon scientific inquiry.** This right implies that sexual information should be generated through the process of unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.

10. **The right to comprehensive sexuality education.** This is a lifelong process from birth throughout the lifecycle and should involve all social institutions.

11. **The right to sexual health care.** Sexual health care should be available for prevention and treatment of all sexual concerns, problems, and disorders.

**SEXUAL RIGHTS ARE FUNDAMENTAL AND UNIVERSAL HUMAN RIGHTS**
PARTICIPANT HANDOUT:
IPPF CHARTER ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS*

The IPPF Charter on Sexual and Reproductive Rights is based on 12 rights, which are grounded in international human rights instruments, and additional rights that IPPF believes are implied by them. It demonstrates the legitimacy of sexual and reproductive rights as human rights by applying internationally agreed language from human rights treaties, which have the status of international law, to sexual and reproductive health and rights issues.

The 12 Rights in the Charter are:

1. **The Right to Life**, which means among other things that no woman's life should be put at risk by reason of pregnancy.

2. **The Right to Liberty and Security of the Person**, which recognizes that no person should be subject to female genital mutilation, forced pregnancy, sterilization or abortion.

3. **The Right to Equality, and to be Free from all Forms of Discrimination**, including in one's sexual and reproductive life.

4. **The Right to Privacy**, meaning that all sexual and reproductive health care services should be confidential, and all women have the right to autonomous reproductive choices.

5. **The Right to Freedom of Thought**, which includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual and reproductive health care and other issues.

6. **The Right to Information and Education**, as it relates to sexual and reproductive health for all, including access to full information on the benefits, risks, and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.

7. **The Right to Choose Whether or Not to Marry and to Found and Plan a Family**

8. **The Right to Decide Whether or When to Have Children**

9. **The Right to Health Care and Health Protection**, which includes the right of health care clients to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.

10. **The Right to the Benefits of Scientific Progress**, which includes the right of sexual and reproductive health service clients to new reproductive health technologies which are safe, effective and acceptable.

11. **The Right to Freedom of Assembly and Political Participation**, which includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.

12. **The Right to be Free from Torture and Ill-treatment**, including the rights of all women, men and young people to protection from violence, sexual exploitation and abuse.
**PARTICIPANT HANDOUT: ATTITUDES ABOUT PEOPLE WHO ENGAGE IN SAME-SEX ACTIVITY (CONFIDENTIAL SURVEY)**

Read the statements below and check the box that most closely matches your opinion about each statement.

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>Agree</th>
<th>Disagree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same-sex sexual activity is wrong.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It should be legal for people to engage in same-sex activity.</td>
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<td></td>
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</tr>
<tr>
<td>Same-sex attraction is probably due to some type of psychological illness.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>I would feel comfortable seeing two men kiss passionately.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think people who are attracted to people of the same sex choose to be that way and could be attracted to people of the opposite sex if they wanted to.</td>
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</tr>
<tr>
<td>Anyone who has sex with someone of the same sex is by definition a homosexual.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>A real man does not have sex with other men.</td>
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<tr>
<td>People of the same sex should be allowed to marry each other.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In our culture, women do not have sex with other women.</td>
<td></td>
<td></td>
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<tr>
<td>It is unacceptable to discriminate in the workplace against people who have same-sex partners.</td>
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<td></td>
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<tr>
<td>People who have same-sex partners should not be allowed to teach children in schools.</td>
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<tr>
<td>I would be very upset if I found out that my daughter was having sex with another woman.</td>
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<tr>
<td>I would be comfortable knowing that a close friend of mine has same-sex partners.</td>
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</table>
**PARTICIPANT HANDOUT: ATTITUDES ABOUT PROVIDING SERVICES TO CLIENTS WHO ENGAGE IN SAME-SEX ACTIVITY (CONFIDENTIAL SURVEY)**

Read the statements below and check the box that most closely matches your opinion about each statement.

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>Agree</th>
<th>Disagree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel comfortable working with a colleague who has same-sex partners.</td>
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<tr>
<td>I would feel comfortable listening to a client discuss same-sex sexual activity.</td>
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<tr>
<td>As a provider I would feel uncomfortable examining clients who told me that they had same-sex partners.</td>
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<tr>
<td>I would rather that clients who have same-sex partners not disclose their sexual behaviors to me.</td>
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<tr>
<td>Providing services to male clients who have sex with other men may put my personal health at risk.</td>
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<tr>
<td>I have the right to refuse services to a female client who tells me that she had sex with another woman.</td>
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<tr>
<td>Our facility should make a special effort to reach out to male clients who have sex with other men.</td>
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<tr>
<td>Clients who have sex with people of the same sex should receive services in a separate part of the clinic away from other clients.</td>
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<td></td>
<td></td>
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<tr>
<td>Some married clients may have same-sex partners, too.</td>
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</tbody>
</table>
PARTICIPANT HANDOUT: HOW DO WE LEARN ABOUT SEX?

Please write short answers to the following questions, identifying two or three main ideas in response to each question.

When you were growing up:

1. What did you learn about sex from your family?

2. What did you learn about sex from your friends?

3. What did you learn about sex from your religion?

4. What did you learn about sex from your schools and teachers?

5. What did you learn about sex from music, movies, newspapers and other media?

6. What did you learn about sex in your professional training or education?

7. What else did you learn about sex and where did you learn it?
PARTICIPANT HANDOUT:
MALE SEXUAL AND REPRODUCTIVE ANATOMY AND PHYSIOLOGY

Circumcised Penis

Uncircumcised Penis
**PARTICIPANT HANDOUT: THE SEXUAL RESPONSE CYCLE**


THE FIVE STAGES OF SEXUAL RESPONSE

**Stage 1: Desire**

Fantasy, memory, or sensual stimuli can create sexual desire – a strong wanting for sexual stimulation. Societal and cultural values influence the range of stimuli that provoke sexual desire. Each individual reacts to sets of stimuli that are idiosyncratic – based on his or her own thoughts, feelings, and experiences.

**Indications of Desire.** Desire is a prelude to sexual excitement and sexual activity – it occurs in the mind rather than the body and may not progress to sexual excitement without further physical or mental stimulation.

**Stage 2: Excitement (arousal)**

Excitement is the body’s physical response to desire. For both sexes, initial physical excitement may be lost and regained many times without progression to the next stage.

**Indications of Excitement:**

- **For both sexes:** Heart rate and blood pressure increase, body muscles tense, sexual flush, nipples become erect, genital and pelvic blood vessels become engorged, and involuntary and voluntary muscles contract.
- **For women:** The vagina lengthens and widens, the clitoris swells and enlarges, breasts increase in size, the labia swell and separate, the vagina becomes lubricated, and the uterus rises slightly. Vaginal lubrication is the key indicator of sexual excitement.
- **For men:** The penis becomes erect, the scrotum thickens, and the testes rise closer to the body. Erection of the penis is the key indicator of sexual excitement.

**Stage 3: Plateau**

If physical or mental stimulation (especially stroking and rubbing of erogenous zones or sexual intercourse) continues during full arousal, the plateau stage may be achieved. This stage may be achieved, lost, and regained without orgasm.

**Indications of the Plateau Stage:**

- **For both sexes:** Breathing rate, heart rate, and blood pressure further increase, sexual flush deepens, and muscle tension increases. There is a sense of impending orgasm.
- **For women:** The clitoris withdraws, the Bartholin’s glands lubricate, the areolae around the nipples become larger, the labia continue to swell, the uterus tips to stand high in the abdomen, and the “orgasmic platform” develops (that is, the lower vagina swells, narrows, and tightens).
- **For men:** The penis is erect and the ridge of the glans penis becomes more prominent, the Cowper’s glands secrete pre-ejaculatory fluid, and the testes rise closer to the body.
Stage 4: Orgasm
During orgasm, the peak of the plateau phase, the sexual tension that has been building throughout the body is released, and the release of body chemicals (endorphins) causes a sense of well-being. Some women are capable of multiple orgasm (moving immediately from orgasm back into the plateau stage and to orgasm again), whereas men must pass through the resolution stage before another orgasm can be achieved.

Indications of Orgasm:
- **For both sexes:** Heart rate, breathing, and blood pressure reach their peak, sexual flush spreads over the body, and there is a loss of muscle control (spasms).
- **For women:** The uterus, vagina, anus, and muscles of the pelvic floor contract five to 12 times at 0.8-second intervals.
- **For men:** Ejaculation (contractions of the ejaculatory duct in the prostate gland that cause semen to be ejected through the urethra and penis) occurs, and the urethra, anus, and muscles of the pelvic floor contract three to six times at 0.8-second intervals.

Stage 5: Resolution
Resolution is the period following orgasm, during which body muscles relax and the body begins to return to its pre-excitement state. Immediately following orgasm, men experience a refractory period, during which erection cannot be achieved (the duration of this period varies among individuals and increases with age). Women experience no refractory period – they can either enter the resolution stage or return to the excitement or plateau stage immediately following orgasm.

Indications of Resolution:
- **For both sexes:** Heart rate and blood pressure dip below normal, returning to normal soon afterward; the whole body (including the palms of hands and soles of feet) sweats; there is a loss of muscle tension, increased relaxation, and drowsiness.
- **For women:** Blood vessels dilate to drain the pelvic tissues and decrease engorgement; the breasts and areolae decrease in size; nipples lose their erection; the clitoris resumes its pre-arousal position and shrinks slightly; the labia return to normal size and position; the vagina relaxes; the cervix opens to help semen travel up into the uterus (closing 20–30 minutes after orgasm); and the uterus lowers into the upper vagina (location of semen after male orgasm during penile-vaginal intercourse).
- **For men:** Nipples lose their erection; the penis becomes softer and smaller; the scrotum relaxes, and the testes drop farther away from the body. Depending on a number of factors (including age), the refractory period in men may last anywhere from five minutes to 24 hours or more.
**PARTICIPANT HANDOUT:**
**SOME COMMON SEXUAL PROBLEMS, CAUSES, AND TREATMENTS**

There are a number of problems or dysfunctions that can occur in the expression of sexuality. This sheet provides basic information on common conditions.

**Loss of desire** affects both men and women, and is characterized by infrequent sexual activity or lack of desire, including few or no sexual dreams or fantasies.

- **Physical factors** that contribute to loss of desire or inhibited sexual desire (ISD) include hormone deficiencies, depression, alcoholism, kidney failure, and chronic illness.
- **Psychological factors** that contribute include stress, relationship problems, sexual trauma, major life changes, and pairing negative memories with sexual interactions.
- **Treatment** is based on the causes of the loss, which may be physical, medical, or psychological. If testosterone deficiency is the cause, replacement therapy is indicated (if available).

**Dyspareunia** is a condition in women characterized by recurrent genital pain with sexual activity (usually with vaginal penetration but can occur during non-penetrative genital stimulation).

- **Symptoms** of dyspareunia include burning, itching, stinging, and feeling inflamed, in any area of the perineum. The main causes are vulvovaginitis, genital herpes, atrophic vulvitis, urethral problems, episiotomy, radiation vaginitis, and sexual trauma, as well as inadequate lubrication and topical irritants such as spermicides or latex. Deep pelvic pain is often associated with thrusting by the partner hitting an ovary during sexual intercourse, pelvic inflammatory disease (PID), pelvic or abdominal surgery, postoperative adhesions, endometriosis, genital or pelvic tumors, irritable bowel syndrome, urinary tract infection, and ovarian cysts. Dyspareunia can also have psychological causes.
- **Treatment** involves treating the physical or psychological causes of the pain.

**Vaginismus** is difficult, uncomfortable, or impossible penetration due to involuntary contractions of vaginal muscles. The case of the condition is often physical or sexual abuse that causes a phobic reaction at the prospect of vaginal penetration. Other causes include painful first intercourse, relationship problems, fear of pregnancy, rape, socialization or upbringing, and belief that the vagina is too small.

- **Treatment** involves a program of specific exercises for relaxing the muscles around the vagina and systematic desensitization of the vagina. The woman learns to control her vaginal muscle spasm while gently introducing inserters of gradually increasing size into her vagina, progressing to the point of being able to introduce her partner’s penis on her own.

**Anorgasmia** is a condition in men and women characterized by a persistent or recurrent delay in or absence of orgasm following a normal sexual excitement or plateau phase. (Note: A woman is **not** anorgasmic if she can achieve orgasm through means other than penile-vaginal stimulation.)

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* From *Sexuality and Sexual Health: On-line Mini-course*, EngenderHealth, 2001,
Causes of anorgasmia in women include anger and hostility toward one's partner, ineffective sexual technique, anxiety, familial or religious teachings that cause women to avoid or actively discourage effective sexual stimulation, and strong fear of loss of control over feelings and behavior. In men the cause is rarely physical and is usually associated with a traumatic sexual experience, socialization or upbringing, hostility, loss of control, or lack of trust.

Treatment involves individual and couple work, focused on treating the desire to “hold back,” treating the fear or phobia of orgasm or losing control, and resolution of conflicts while increasing stimulation.

Premature ejaculation (PE) 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. PE 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.”

Causes of PE are rarely physical; some infections of the urethra and prostate, neglected gonorrhea, and overly tight uncircumcised foreskin have been considered as possible causes. Most commonly, the man has not learned to pay attention to the sensory feedback that lets him know that ejaculation is imminent.

Treatment interventions may include psychological approaches aimed at reducing anxiety and improving ejaculatory control through special techniques, such as “pause and squeeze”; using latex condoms to reduce sensation; drug therapy (if available) with the use of formulations that delay ejaculation can improve sexual satisfaction in the client and his partner.

Erectile dysfunction (ED) is a condition in men characterized by persistent or recurrent inability to attain or maintain erection until completion of sexual activity.

Causes can include alcohol, diabetes, drugs, HIV, multiple sclerosis, Parkinson’s disease, or spinal cord lesions. Causes may be psychological, physical, or a combination of both.

Treatment approaches depend on the cause of the dysfunction and may include (if available):

- Intracavernosal injection of medication or combination of drugs (e.g., Papverine)
- Intraurethral pellets (e.g., prostaglandin)
- Oral preparations (sildenafil)
- Hormonal augmentation (testosterone)
- Surgical options
- Working with partner to address psychological issues through sex therapy techniques
**PARTICIPANT HANDOUT: STAGES OF FEMALE AND MALE SEXUAL DEVELOPMENT**

<table>
<thead>
<tr>
<th>STAGE</th>
<th>FEMALE DEVELOPMENT</th>
<th>MALE DEVELOPMENT</th>
<th>AGE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• No breast budding</td>
<td>• Pre-pubertal, small penis and testes</td>
<td>&lt;10 years</td>
</tr>
<tr>
<td></td>
<td>• No pubic hair growth</td>
<td>• No pubic hair growth</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>• Small breast buds</td>
<td>• Testes grow</td>
<td>10–13</td>
</tr>
<tr>
<td></td>
<td>• Fine, delicate, fuzzy pubic hair growth</td>
<td>• Scrotal skin becomes coarser</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>• Enlarging breast buds</td>
<td>• Penis lengthens, with small increase in diameter</td>
<td>12–14</td>
</tr>
<tr>
<td></td>
<td>• Increased, coarser pubic hair, mainly in the center and not extending out to thighs or upward</td>
<td>• Scrotum and testes continue to grow</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breast forms mounds</td>
<td>• Pubic hair increases in amount and becomes coarser and curly</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>• Noticeable growth of pubic hair in a triangle, the shape it will take in adulthood</td>
<td>• Penis and testes continue to grow</td>
<td>13–15</td>
</tr>
<tr>
<td></td>
<td>• Underarm hair growth visible</td>
<td>• Pubic hair increases in amount and becomes coarser and curly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breasts form mounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Menarche (may occur earlier, as early as age 9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>• Breasts fully formed</td>
<td>• Penis is at its full adult size</td>
<td>14–17</td>
</tr>
<tr>
<td></td>
<td>• Pubic hair is adult in quantity and forms an upside-down triangle, a shape common to women</td>
<td>• Pubic hair is at its adult texture and distribution</td>
<td></td>
</tr>
</tbody>
</table>

PARTICIPANT HANDOUT: MILESTONES IN MALE AND FEMALE
SEXUAL AND SOCIAL DEVELOPMENT*

Begins to have sexual responses
Occurs before birth. A male fetus achieves genital erections in utero; some males are even born
with erections. Sexual responses in females are also present before birth.

Explores and stimulates one’s own genitals (masturbates) for the first time
Occurs between age six months and one year. As soon as babies can touch their genitals, they
begin to explore their bodies.

Shows an understanding of gender identity
Occurs by age two. Children are aware of their biological sex.

Shows an understanding of gender roles
Occurs between ages three and five. Children begin to conform to society’s messages about how
males and females should act.

Asks questions about where babies come from
Occurs between ages three and five.

Begins to show romantic interest
Occurs between ages five and 12, though this may vary by culture. At this stage, children show
the first signs of sexual orientation (sexual preference toward males or females).

Shows the first physical signs of puberty (the transition from childhood to maturation)
Occurs between ages eight and 12. This usually occurs slightly earlier for girls than boys.

Begins to produce sperm (boys)
Occurs between ages 11 and 18. This milestone depends in part on the child’s nutrition and
might be delayed when nutrition is severely compromised.

Begins to menstruate (girls)
Occurs between ages nine and 16. This milestone depends in part on the child’s nutrition and
may be delayed where nutrition is severely compromised.

Begins to engage in romantic activity
Occurs between ages 10 and 15. This milestone depends heavily on cultural factors.

Has sex for the first time
Varies greatly by culture, but middle to late adolescence is fairly common across cultures.

* From Men as Partners: A Program for Supplementing the Training of Life Skills Educators,
EngenderHealth/Planned Parenthood Association of South Africa, 2001)
Gets married
Varies greatly by culture.

Begins to bear children
Varies based on individual and community factors.

Experiences menopause
Occurs in women at around age 50 (it can start in their late 30s or early 40s as well). A woman goes through a process of physiological changes characterized by the end of ovulation, menstruation, and the ability to reproduce.

Experiences male climacteric (decreased male hormone levels)
Occurs between ages 45 and 65. A man goes through a process of physiological changes characterized by a decrease in testosterone production.

Experiences sexuality in later life
Older adults (those aged 50 to 60 or beyond) can remain sexually active to the end of their lives. Though some age-related changes in sexuality take place, the total loss of sexual functioning is not a part of the normal aging process.
PARTICIPANT HANDOUT:
NORMAL CHANGES IN SEXUAL RESPONSE WITH AGING*

Sexual activity can continue throughout one’s lifetime, and one’s later years can offer a rich sex life without the worry of pregnancy and effective contraception. However, the risk of sexually transmitted infections is still present for older adults.

The aging process does affect sexual responses and function, the response cycle slows down somewhat, responses within phases take longer, genitalia are somewhat less sensitive, and excitement and orgasmic sensations are diminished yet pleasurable. The following effects are common in older adults.

WOMEN
Changes in the Excitement stage:
- Decreased libido following menopause
- Delayed nipple erection
- Reduced labial separation; labial swelling; vaginal changes (e.g., vaginal expansion)
- Delayed and less lubrication
- Decreased elevation of the uterus
- Reduced muscle tension

Changes in the Orgasm stage:
- Women in their 30s and 40s may achieve orgasm more readily than younger women
- Reduced spread of sexual flush

MEN
Changes in the Excitement stage:
- Delayed and less-firm erection
- Delayed nipple erection (but nipple erection lasts longer after orgasm)
- Longer excitement stage
- Decreased pre-ejaculatory emissions
- Longer interval to ejaculation
- More direct stimulation required to achieve and maintain erection
- Reduced muscle tension
- Diminished lifting of scrotum and testes with more rapid return to pre-arousal state

Changes in the Orgasm stage:
- Shorter ejaculation time, with reduced volume, fewer ejaculatory contractions
- Shortened phase of impending orgasm and expulsion of semen

Changes in the Resolution stage:
- More rapid loss of erection
- Longer refractory period

* (from Sexuality and Sexual Health: On-line Mini-course, EngenderHealth, 2001,
http://www.engenderhealth.org/res/one/sexuality/index.html)
VOLUME 2

SECTION TWO: INTRODUCTION TO HIV/STI PREVENTION AND DUAL PROTECTION

(PARTICIPANT HANDOUTS)
## PARTICIPANT HANDOUT:
### HIV/STI RISK CONTINUUM – SUMMARY TABLE

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>RISK</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td>No Risk</td>
<td></td>
</tr>
<tr>
<td>Masturbation</td>
<td>No Risk</td>
<td></td>
</tr>
<tr>
<td>Sex with a monogamous, uninfected partner/spouse</td>
<td>No Risk</td>
<td>It may be difficult to know if partner/spouse is monogamous and uninfected. Even if monogamy is practiced, people may have been infected before becoming involved in a relationship or getting married.</td>
</tr>
<tr>
<td>Unshared sex toys</td>
<td>No Risk</td>
<td>Provided there is no exchange of bodily fluids between partners.</td>
</tr>
<tr>
<td>Shaking hands with an HIV-infected person</td>
<td>No Risk</td>
<td></td>
</tr>
<tr>
<td>Sitting on a public toilet seat</td>
<td>No Risk</td>
<td></td>
</tr>
<tr>
<td>Getting bitten by a mosquito</td>
<td>No Risk</td>
<td></td>
</tr>
<tr>
<td>Hugging an HIV-positive person/shaking hands with an HIV-positive person</td>
<td>No Risk</td>
<td></td>
</tr>
<tr>
<td>Sharing sex toys with cleaning or use of new condom</td>
<td>Low Risk/No risk</td>
<td>Risk is very low if there are no cuts or broken skin on hands especially if there is no contact with secretions, semen or menstrual blood.</td>
</tr>
<tr>
<td>Sexual stimulation of another’s genitals using hands</td>
<td>Low Risk/No risk</td>
<td>Risk is very low if there are no cuts or broken skin on hands especially if there is no contact with secretions, semen or menstrual blood.</td>
</tr>
<tr>
<td>Deep (tongue) kissing</td>
<td>Low Risk/No risk</td>
<td>Risk is higher if bleeding gums, sores or cuts in mouth. No risk due to saliva itself.</td>
</tr>
<tr>
<td>Oral sex on a woman (cunnilingus) with a barrier</td>
<td>Low Risk/No risk</td>
<td>Risk is very low. Barrier must be used correctly. Some STIs (e.g. herpes) can be transmitted through contact with skin not covered by barrier.</td>
</tr>
<tr>
<td>Oral Sex on a man (fellatio) with a condom</td>
<td>Low Risk/No risk</td>
<td>Risk is very low. Barrier must be used correctly. Some STIs (e.g. herpes) can be transmitted through contact with skin not covered by barrier.</td>
</tr>
<tr>
<td>Vaginal Sex with a condom</td>
<td>Low Risk</td>
<td>Small risk of condom slippage or breakage – reduced with correct use. Some STIs (e.g. herpes) can be transmitted through contact with skin not covered by condom.</td>
</tr>
<tr>
<td>Vaginal sex with multiple partners; condom use every time</td>
<td>Low Risk</td>
<td>Multiple partners increases risk, however correct and consistent condom use lowers risk.</td>
</tr>
<tr>
<td>Vaginal sex with withdrawal prior to ejaculation</td>
<td>High Risk</td>
<td>Transmission of HIV/STI can happen through exchange of bodily fluids such as semen (which can be discharged during intercourse prior to ejaculation) and vaginal secretions.</td>
</tr>
<tr>
<td>PRACTICE</td>
<td>RISK</td>
<td>NOTES</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Anal sex with a condom</td>
<td>Medium Risk</td>
<td>Risk of condom breakage greater than for vaginal sex. Some STIs (e.g. herpes) can be transmitted through contact with skin not covered by barrier.</td>
</tr>
<tr>
<td>Anal sex with multiple partners; condom use every time</td>
<td>Medium risk</td>
<td>Multiple partners increases risk, however correct and consistent condom use lowers risk. Some STIs (e.g. herpes) can be transmitted though contact with skin not covered by barrier, therefore sex with multiple partners results in increased risk.</td>
</tr>
<tr>
<td>Getting bitten by a mosquito</td>
<td>No Risk</td>
<td>HIV and STIs are not transmitted by mosquitoes.</td>
</tr>
<tr>
<td>Helping someone with a nosebleed</td>
<td>Low Risk/No Risk</td>
<td>It is always important to follow infection prevention measures (e.g. using disposable gloves) and ensure that there is no direct blood contact with the skin.</td>
</tr>
<tr>
<td>Oral Sex on a man (fellatio) without a condom</td>
<td>Medium Risk</td>
<td>HIV and STIs can be transmitted through oral sex, however risk is lower than that of anal or vaginal sex. Safer if no ejaculation in mouth.</td>
</tr>
<tr>
<td>Oral sex on a woman (cunnilingus) without a barrier</td>
<td>Medium Risk</td>
<td>HIV and STIs can be transmitted through oral sex, however risk is lower than for anal or vaginal sex.</td>
</tr>
<tr>
<td>Oral-anal sex (rimming)</td>
<td>Medium risk</td>
<td>HIV and STIs can be transmitted through oral sex, however risk is lower than for penetrative sex.</td>
</tr>
<tr>
<td>Massage</td>
<td>No Risk</td>
<td>If people are unclothed, they should first check that they have no sores or cuts on their bodies.</td>
</tr>
<tr>
<td>Vaginal sex using spermicides or diaphragm and no condoms</td>
<td>High Risk/Reduced Risk</td>
<td>The risk of transmission of HIV and STIs during vaginal sex may be reduced when spermicides are used. Spermicides do not eliminate the risk of HIV/STI transmission. Very frequent use of spermicides (multiple times in a single day) can damage tissues increasing risk. Diaphragms can also reduce risk of some STIs, but they do not protect from HIV</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>High Risk/Reduced Risk</td>
<td>HIV can be present in pre-ejaculate, and therefore, risk of transmission is high, however withdrawal may reduce risk of HIV transmission somewhat. Unlikely to reduce risk of other STIs.</td>
</tr>
<tr>
<td>Vaginal sex without a condom</td>
<td>High Risk</td>
<td>One of the highest risk activities. Receptive partner is at greater risk. Risk increases with the increased number of partners with whom unsafe sex is practiced.</td>
</tr>
<tr>
<td>Anal sex without a condom</td>
<td>High Risk</td>
<td>One of the highest risk activities. Receptive partner is at greater risk because the tissue lining the rectum is highly susceptible to micro-lesions and tears during anal intercourse. Risk increases with the increased number of partners with whom unsafe sex is practiced.</td>
</tr>
<tr>
<td>Vaginal sex using hormonal contraceptives or an IUD &amp; no condom</td>
<td>High Risk</td>
<td>Hormonal contraceptives and IUDs do not protect against STIs or HIV.</td>
</tr>
<tr>
<td>PRACTICE</td>
<td>RISK</td>
<td>NOTES</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Using sharp instruments to cut skin (e.g. instruments used for scarification, FGM, tattoos, piercing)</td>
<td>High Risk</td>
<td>If these instruments have been used on others and are not properly processed, HIV and hepatitis viruses could be transmitted.</td>
</tr>
<tr>
<td>Sharing needles, syringes, drugs or other drug paraphernalia</td>
<td>High Risk</td>
<td>HIV and hepatitis viruses can readily be transmitted from an infected person through sharing of injection drug works</td>
</tr>
<tr>
<td>Breastfeeding from an HIV-infected mother</td>
<td>High Risk</td>
<td>Although the risk is relatively high, if no other good source of nutrition is available, it is recommended that an HIV-positive woman breastfeed.</td>
</tr>
<tr>
<td>Donating and receiving blood</td>
<td>Unknown Risk</td>
<td>If infection prevention measures are correctly applied, donating blood should not pose a risk for donors. In many countries the blood supply is adequately screened for HIV, therefore blood transfusions should not result in transmission of HIV.</td>
</tr>
<tr>
<td>Occupational exposure to blood or body fluids</td>
<td>Risk varies depending on type of exposure</td>
<td>HIV and other bloodborne pathogens can be transmitted through contact with blood or other body fluids. Risk can be minimized if standard precautions are followed with all clients.</td>
</tr>
<tr>
<td>Sex without condom with a man who has had a vasectomy</td>
<td>High risk</td>
<td>Vasectomy does not protect from HIV or STIs and these infections can be transmitted through semen.</td>
</tr>
<tr>
<td>Rubbing sweaty bodies together</td>
<td>No risk/low risk</td>
<td>Some STIs (e.g. herpes) can be transmitted though contact with skin not covered by barrier if there are lesions.</td>
</tr>
<tr>
<td>Sex with a circumcised man without condom use</td>
<td>High risk</td>
<td>There is evidence that circumcised men can be at reduced risk of acquiring HIV/STIs because the absence of foreskin prevents bodily fluids from getting trapped and thus exposure to infection is reduced. However, this does not mean that male circumcision prevents HIV/STI transmission nor it means that infected circumcised men are less likely to transmit infection to their sexual partners. Practitioners must continue to stress to both uncircumcised and circumcised men the importance of condom use and safer sex practices.</td>
</tr>
<tr>
<td>Having “dry” vaginal sex</td>
<td>High risk</td>
<td>“Dry” vaginal sex refers to practices in which vaginal secretions are prevented or eliminated to increase attrition and pleasure for the man. “Dry” sex is risky because it increases the likelihood of vaginal raptures as well as the risk of condom breakages.</td>
</tr>
<tr>
<td>Vaginal/anal intercourse using oil-based lubricants and condoms</td>
<td>High risk</td>
<td>Oil-based lubricants can seriously damage condoms and therefore increase the likelihood of breakages during intercourse.</td>
</tr>
<tr>
<td>Using the same condom twice</td>
<td>High risk</td>
<td>Condoms should never be re-used, as re-use is not hygienic and increases the likelihood of breakages and slippage.</td>
</tr>
<tr>
<td>PRACTICE</td>
<td>RISK</td>
<td>NOTES</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Telling each other sexual fantasies</td>
<td>No risk</td>
<td>It can increase intimacy and pleasure with no risk of infection. It may enhance safer sex practices and thus motivate people to practice safer sex.</td>
</tr>
<tr>
<td>Swimming in a public pool</td>
<td>No risk</td>
<td></td>
</tr>
<tr>
<td>Biting as part of sexual play</td>
<td>No risk/low risk</td>
<td>It’s no risk if there are no lesions/open sores/cuts in the mouth and provided that the biting does not cause the person to bleed.</td>
</tr>
<tr>
<td>Vaginal intercourse during menstruation</td>
<td>High risk</td>
<td>Risk is heightened because of the possible contact with blood.</td>
</tr>
<tr>
<td>without condom use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Going to the dentist</td>
<td>No risk</td>
<td>Provided that dentists use consistently and correctly infection control measures.</td>
</tr>
<tr>
<td>Sharing needles cleaned with bleach</td>
<td>Reduced risk</td>
<td>If needles are cleaned with full strength bleach and thoroughly rinsed with clean water and this procedure is followed before each new person uses them.</td>
</tr>
<tr>
<td>Labor and delivery (risk to child)</td>
<td>High risk</td>
<td>HIV can be transmitted during labor and delivery. However, there are now very short drugs regimes using Nevirapine that can reduce transmission (refer to MTCT section).</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>High risk</td>
<td>If the mother is infected, HIV can be transmitted to the child through breastfeeding. However, in some cases exclusive breastfeeding is recommended even if the mother is infected if there are no other viable option to feed the baby (refer to MTCT section for details)</td>
</tr>
<tr>
<td>Performing a pelvic examination without</td>
<td>High risk</td>
<td>Lack of infection prevention measures can seriously increase the risk of RTIs.</td>
</tr>
<tr>
<td>gloves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning up a blood spill with latex gloves</td>
<td>No/Low risk</td>
<td>If infection prevention measures are used correctly, this procedure should not pose any risk.</td>
</tr>
<tr>
<td>Sex with a commercial sex worker</td>
<td>High/Medium/Low</td>
<td>Risk depends on the sero status of a person and on their sexual practices. Although commercial sex workers are potentially more at risk because of their higher number of sexual partners, the key issue in terms of preventing HIV/STI transmission is practicing safer sex consistently.</td>
</tr>
<tr>
<td>Rubbing genitals together fully clothed</td>
<td>No risk</td>
<td></td>
</tr>
<tr>
<td>Rubbing genitals together without penetration, unclothed</td>
<td>No risk</td>
<td>Provided that there are no lesions (some STIs, like herpes, can be transmitted through contact with skin not protected by barriers) and no exchanges of bodily fluids (i.e., semen, blood, vaginal fluids)</td>
</tr>
<tr>
<td>Having sex with someone of the same sex</td>
<td>No risk</td>
<td>Provided that people practice safer sex.</td>
</tr>
<tr>
<td>Manual sexual stimulation</td>
<td>No risk</td>
<td>Provide that basic hygiene is ensured in order to prevent possible RTIs.</td>
</tr>
</tbody>
</table>
Biological factors that may increase risk of HIV and STI transmission:

- Persons with open sores, lesions or abrasions on the vagina, mouth, anus or penis are at higher risk of HIV or STI infection if exposed during unprotected sex.
- The tissue lining the rectum is very susceptible to micro-lesions and tears during anal intercourse thus creating entry points for HIV and other STIs to enter the bloodstream if intercourse is unprotected.
- Adolescent girls whose vaginal tissue is not fully matured can develop more likely to develop micro-lesions during intercourse and are thus at higher risk of becoming infected with HIV and other STIs when exposed during unprotected intercourse.
- Someone with an STI, particularly an ulcerative STI such as syphilis or chancroid, is more likely to become infected with HIV if exposed.
- Men who are uncircumcised are more likely to become infected with HIV if exposed during unprotected vaginal sex than men who are circumcised.
- A person with advanced HIV disease or AIDS has a higher viral load and is thus more likely to pass the infection on during unprotected sex than an HIV-positive person who is healthy.
- An HIV-infected pregnant woman who is healthy and well nourished, and thus has a lower viral load, is less likely to transmit the virus to her baby during pregnancy, labor, or breastfeeding.
- An HIV-infected breastfeeding mother is more likely to transmit the virus to her baby while breastfeeding if she has cracked and bleeding nipples (mastitis, breast abscess, nipple fissure).

Why is it important to understand the social and cultural dimensions that influence people’s own perceptions of risk and their ability to bring about behavior change?

- Perceptions about risk are very personal – each individual will have a different attitude about risk in their life.
- Sexual desire or passion may overshadow thoughts of potential risk.
- Young people are more likely to take risks than older people; youth often see themselves as invincible.
- Some people may feel comfortable engaging in lower-risk activities (e.g. having oral sex), while others may not be willing to take any risks.
- Some may not worry about risk for HIV when they are faced with what they consider more pressing concerns like feeding their family, the threat of violence in their community, or other life threatening illnesses.
- Some people, particularly women, may recognize risk in their lives but may not be able to reduce the risk (e.g. women may not be able to ask their male partners to use condoms).
• Some people may be worried about their risk but more afraid of the consequences of talking about their sexuality (for example a man who has sex with other men might fear being ostracized).

• We need to become more aware of our own beliefs and values and make sure that they don’t hinder our ability to provide client-centered, quality services to all who need them.

Other factors that may influence risk perception:
• Not knowing the risky practices (both sexual and otherwise) of your partner.
• Perceptions about the effectiveness of protective measures.
• People (women in particular) believing that being monogamous is sufficient.
• Perceptions of invincibility, particularly among adolescents.
• Perceptions about being or not being in a known “risk group”.
• People often underestimate risks related to personal behaviors – even when they may be concerned about outside threats such as violence or accidents.
## Participant Handout: Contraceptive Methods: Effectiveness, Impact on Sexuality, and Prevention of HIV/STI Transmission

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td>Effectiveness varies depending on whether abstinence is continuous or periodic (0-25% failure rate).</td>
<td>Enhances alternative expressions of sexual pleasure.</td>
<td>Can be very difficult to negotiate, particularly in contexts where women have limited control over their sexual activity and/or when partners have already developed a sexual relationship and would need a compelling reason to stop engaging in sexual activity.</td>
<td>Provides effective protection only when continuous.</td>
</tr>
<tr>
<td></td>
<td>Or</td>
<td>Security of protection against unwanted pregnancy and STI/HIV transmission can increase sexual freedom and enhance pleasure.</td>
<td>Can dramatically affect relationships and/or how people are perceived in their communities in contexts where sexual activity is an expected and desired aspect of relationships.</td>
<td>Small risk of HIV transmission through oral sex, some other STIs can be transmitted through oral sex</td>
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<td>b. Abstinence from non-penetrative penile/vaginal, penile/anal intercourse</td>
<td></td>
<td>When periodic, worry over lack of protection against STI/HIV transmission can diminish enjoyment.</td>
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**Abstinence**

- Abstinence from all sex

Or

- Abstinence from non-penetrative penile/vaginal, penile/anal intercourse
## Contraceptive Method Effectiveness Rates: Family Planning

### Impact on Sexuality: Potential Positive Effects
- Enhances men’s sensitivity to sensations leading to ejaculation, potentially supporting men’s efforts to control pre-mature ejaculation.

### Impact on Sexuality: Potential Negative Effects
- Women lack control over their own protection and may worry about their partner withdrawing on time.
- Interrupting sexual activity can diminish pleasure for both male and female partners.
- Worry over lack of protection against HIV/STI transmission can diminish enjoyment.

### HIV/STI Transmission
- Does not protect against HIV or STIs, but reduces risk somewhat.
- Pre-ejaculatory fluid can contain HIV.

### Coitus Interruptus
- Available data shows that coitus interruptus provides efficacy similar to that of contraceptive barrier methods (4-18% failure rate).
- Enhances men’s sensitivity to sensations leading to ejaculation, potentially supporting men’s efforts to control pre-mature ejaculation.

### Fertility Awareness
- Effectiveness depends upon three main factors: (1) accuracy in identifying the woman’s fertile days, (2) correct identification of fertile time, (3) partners’ ability to follow the rules of the method they have chosen (2-20% failure rate).
- Enhances creativity in sexual expression when avoiding penile-vaginal contact is required.
- Some men may seek secondary sex partners during periods of abstinence.
- Offers no protection against HIV or STIs.
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<tr>
<td><strong>Lactational Amenorrhea Method (LAM)</strong></td>
<td>• LAM requires “full or nearly full breastfeeding” during the first 6 months after delivery to be effective (0.5-1.5% failure rate).</td>
<td>• Increased breast size may be arousing. • Breast sensations during breastfeeding may be erotic.</td>
<td>• Low estrogen can result in diminished vaginal lubrication. • May experience reduced desire or loss of desire. • May eliminate sexual activity in settings where sex with breastfeeding women is taboo. • Worry over lack of protection against HIV/STI transmission can diminish enjoyment.</td>
<td>• Offers no protection against HIV or STIs.</td>
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<tr>
<td><strong>Male Condom</strong></td>
<td>• 2-12% failure rate • Consistent and correct use are important to assure efficacy</td>
<td>• Can reduce penile sensation and prevent/minimize premature ejaculation. • Protection against HIV/STI transmission can enhance sense of freedom and pleasure. • Requires communication between partners and active male participation</td>
<td>• Can reduce penile sensation. • Some men may not be able to maintain an erection with condom use. • May cause latex allergy. • Must be put on once penis is erect. • Must withdraw immediately after ejaculation, possibly interrupting intimacy and sexual pleasure • Lack of skin to skin contact can diminish pleasure</td>
<td>• Offers the best protection against HIV and STIs.</td>
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| **Female Condom**    | • 3-21% failure rate                | • Protection against HIV/STI transmission can enhance sense of freedom and pleasure.  
  • Does not reduce penile sensation.  
  • Can be inserted prior to arousal and thus does not interrupt sexual activity.  
  • May increase women’s control over their sexual activity.  
  • Requires communication between partners. | • Can be noisy  
  • May be considered unattractive.  
  • Lack of skin to skin contact can diminish pleasure | • Offers protection against HIV and STIs. |
| **Spermicides**      | • 3-21% failure rate  
  • Can be used with a diaphragm or condom. | • Increase in vaginal lubrication may reduce discomfort during intercourse and potentially increase pleasure for women and men  
  • May increase women’s control over their sexual activity. | • Unpleasant tasting (oral-genital sex).  
  • Increase in vaginal lubrication may decrease pleasure.  
  • May irritate genitalia of woman and/or man.  
  • It is necessary to wait a few minutes after inserting tablets or suppositories before engaging in intercourse.  
  • Worry over lack of protection against HIV/STIs can diminish enjoyment. | • Does not protect against HIV. While nonoxynol-9 has been shown to kill HIV in a laboratory, this has not been proven in actual use.  
  • Frequent use can cause irritation which may facilitate HIV transmission.  
  • Offers some protection against certain STIs. |
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<tr>
<td>Diaphragm</td>
<td>6-18% failure rate</td>
<td>Can be inserted ahead of time and thus will not interrupt sexual activity.</td>
<td>Women may experience pelvic discomfort if size is too large.</td>
<td>Can help protect against certain STIs, PID, and cervical dysplasia/cancer.</td>
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<td>When inserted properly, it cannot be felt by the woman or the man.</td>
<td>Carrying or inserting ahead of time may imply expectation of intercourse.</td>
<td>Does not protect against HIV.</td>
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<td>May require communication between partners.</td>
<td>Difficulty inserting diaphragm and additional spermicide for repeated intercourse can interrupt and be distracting.</td>
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<td></td>
<td>Worry over lack of protection against HIV/STI transmission can diminish enjoyment.</td>
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<tr>
<td></td>
<td>6-18% failure rate</td>
<td>The removal of the fear of pregnancy may increase a sense of sexual pleasure.</td>
<td>Increased bleeding, pain or discomfort can diminish sexual desire or enjoyment.</td>
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<tr>
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<td></td>
<td>Sexual activity is not interrupted.</td>
<td>Worry over lack of protection against HIV/STI transmission can diminish enjoyment.</td>
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<td></td>
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<td>Provides a sense of freedom since there is no need to remember to use the method once it is inserted.</td>
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<tr>
<td>IUD</td>
<td>0.8-3% failure rate</td>
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<td>Offers no protection against HIV or STIs.</td>
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| Combined oral/injectables    | • 0.1 –3% failure rate               | • The removal of the fear of pregnancy may increase a sense of sexual pleasure.  
• Improves perimenopausal symptoms.  
• Sexual activity is not interrupted.  
• For some women, shorter, more regular and less painful periods can improve sexual life. | • May decrease vaginal lubrication.  
• Reduces free testosterone sometimes resulting in diminished desire or loss of desire.  
• Worry over lack of protection against HIV/STIs can diminish enjoyment. | • Offers no protection against HIV or STIs.  
• Some evidence indicates that oral contraceptives may increase the risk of transmission from an infected woman to her partner. |
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<tr>
<th>Emergency Contraception</th>
<th>• 0.5-2.5% failure rate</th>
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<th>• Offers no protection against HIV and STIs.</th>
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<tbody>
<tr>
<td>Progestin-only orals/injectables/implants</td>
<td>• 0.3-0.4% failure rate</td>
<td>• The removal of the fear of pregnancy may increase a sense of sexual pleasure.</td>
<td>• May reduce sexual activity in settings where sex with bleeding (spotting) women is taboo or if sex in the presence of vaginal bleeding is not appealing.</td>
<td>• Offers no protection against HIV or STIs.</td>
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<td>• Sexual activity is not interrupted.</td>
<td>• Increased bleeding in some women can cause discomfort.</td>
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<td>• Provides a sense of freedom since there is no need to remember to use the method for up to 3 months.</td>
<td>• Some women report that it diminishes sexual desire.</td>
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<td>• Absence or diminution of menstruation may enhance sexual life, although many women consider absence of period undesirable.</td>
<td>• Worry over lack of protection against HIV/STIs can diminish enjoyment.</td>
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</table>
| Tubal occlusion      | • 0.2-0.4% failure rate              | • Security of protection against pregnancy can increase sexual freedom and enhance pleasure.  
• Sexual activity is not interrupted.  
• Provides a sense of sexual freedom since there is no need to remember to use a method.  
• The free and voluntary decision to terminate fertility can produce a sense of freedom and well-being. | • As it removes the risk of unwanted pregnancy, it may discourage men from taking responsibility for safer sex practices.  
• Worry over lack of protection against HIV/STI transmission can diminish enjoyment. | • Offers no protection against HIV or STIs,  
• Since sterilization patients often do not return to family planning clinics, it is particularly important to discuss HIV/STI prevention prior to the procedure. |
| Vasectomy            | • 0.1-0.15% failure rate             | • Security of protection against pregnancy can increase sexual freedom and enhance pleasure.  
• Following vasectomy, a man has the same appearance, desire and capacity to have sexual relations as prior to the vasectomy.  
• Sexual activity is not interrupted.  
• Provides freedom from remembering to use a method. | • As it removes the fear of unwanted pregnancy, it may discourage men for taking responsibility for safer sex practices.  
• Worry over lack of protection against HIV/STI transmission can diminish enjoyment. | • Offers no protection against HIV or STIs.  
• While semen does not contain sperm after vasectomy, it can contain HIV. |
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<tr>
<td>Data unavailable (assumed to be at least as effective as the lower efficacy method with typical use and as high or higher than the higher efficacy method with perfect use).</td>
<td>Security of protection against unwanted pregnancy and STI/HIV transmission can increase sexual freedom and enhance pleasure. Requires communication between partners.</td>
<td>May require additional support for partners to develop communication and negotiation skills.</td>
<td>Offers protection against STI and HIV.</td>
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PARTICIPANT HANDOUT:
CASE STUDIES ON CONTRACEPTION, SEXUALITY AND HIV/STIs

Case study 1:
Ana is a 22-year old woman who has been married for 4 years. She has 2 young children. She knows that her husband has other partners and has recently convinced him to use condoms as a form of birth control because she told him that she would like to wait a while to have another child. She reveals to you that the real reason she would like to use condoms is to protect herself from STIs. Since they’ve been using condoms, however, her husband has been having problems maintaining his erection during sex. He now refuses to use condoms. The whole problem has gotten so bad that he is drinking a lot and even avoiding sex. Ana is confused and worried that his losing his erection is her fault. She really would like him to use condoms, though.

How do you counsel her?

Case study 2
Valerie, an 18-year old student, comes to your clinic because she has recently become sexually active for the first time and wants a family planning method. She chooses oral contraceptives, but returns a few weeks later complaining that her partner says she is “too wet.” She thinks that the pills are causing the wetness and asks about switching methods.

What could be causing the “wetness” and what issues would you have to explore with Valerie to provide her with good counseling?
PARTICIPANT HANDOUT: HIV VOLUNTARY COUNSELING AND TESTING (VCT)

What is an HIV test?
- An HIV test is used to determine whether or not a person is infected with human immunodeficiency virus (HIV), which causes AIDS. An HIV test usually involves taking a sample of blood, oral fluid (fluid from the mouth), or urine from a person and then analyzing the sample in a laboratory. These tests look for antibodies to HIV. Antibodies are proteins produced by the immune system to fight a specific germ.
- However, when a person is infected with HIV, it generally takes three months, and sometimes up to six months, for his or her body to produce detectable levels of antibodies (96% of infected individuals develop antibodies within 12 weeks). This length of time is called the window period. During this period, a person will not test positive even if he or she is infected with HIV. The most common HIV tests are more than 99.5% accurate.
- Anyone who has an HIV test should only do so voluntarily. It is strongly recommended that clients be counseled both before and after taking the test.

What is pre-test counseling?
- Pre-test counseling provides an opportunity for counselors and clients to talk about the HIV test process, the meaning of positive and negative test results, the client’s potential HIV risks, ways to reduce HIV risk, and the client’s intended plan of action once he or she gets the test result.
- In addition, before the actual test, the counselor should ensure that the client is getting tested voluntarily and has the information he or she needs to make an informed decision about proceeding with the test.

What happens if the test results are positive?
- A positive HIV test indicates the presence of HIV antibodies and means the person is infected with HIV. Testing positive does not mean that the person has AIDS. Many people who test positive stay healthy for several years, even without treatment.
- If a client tests positive, the counselor should explain what a positive result means, address the client’s emotional response, answer any questions, discuss treatment options (if they exist) and self care, discuss how the client can avoid transmitting the virus to others, and set up referrals for health care and social support services. A counselor should also address family planning options, if desired.
- Women who test positive and are pregnant should be counseled on options available to prevent mother-to-child transmission (MTCT) of HIV, including termination of pregnancy if desired and legal. They should be referred to programs specializing in the prevention of MTCT.

What happens if the test results are negative?
- A negative HIV test result means that no HIV antibodies were present in the person’s body at the time of the test. If a person tests negative and has not been exposed to HIV in the past six months, most likely the individual is not infected with HIV.
• When disclosing a negative test result, the counselor should explain what the test result means, discuss the *window period*, indicate whether or not the client should return for another test, answer any questions the client might have, address the client’s emotional response, suggest strategies for remaining HIV-negative, and talk to the client about his or her personal risk reduction plan.

**Once a person becomes infected with HIV, how long does it take for antibodies to the virus to show up in a test?**

• When someone becomes infected with the virus, HIV antibodies usually show up in his or her blood within three months of the date of infection. Therefore, it can take up to three months after infection before a test shows someone to be HIV-infected (the window period). The person might have contracted the virus one or two months before the test – or the previous night. So although a person’s test result is negative, he or she might still be infected.

• If an individual thinks that he or she might have HIV and would like to take a test to find out, it is recommended that he or she be tested. If the result is negative, encourage the person to have another test three months later. If this test is also negative and the person has not been exposed to the virus in the meantime and continues to practice safer sex, it is unlikely that he or she is HIV-infected.

**Can a person be tested for HIV without permission?**

• Unfortunately, this has been a common occurrence in some countries. Clients have the right to know which tests providers intend to conduct and the right to refuse tests they do not want.

• Some countries have laws that protect people from being given treatments and tests without their permission. These laws state that a person must understand the nature of the test and give his or her oral or written consent. With an HIV test, before agreeing to having the blood drawn an individual must know what the test is, why it is being done, and what the result will mean for him or her. The explanations, which are given before a test is done, are part of **pre-test counseling**. A person should also be helped to determine whether or not having the test is the right decision for him or her.

• It is inappropriate for health care facilities to require pre-surgical HIV testing. Rather, health care facilities should ensure that all health care providers follow universal precautions to prevent exposure to HIV.

**What are some implications of VCT for pregnant women?**

• HIV has consequences for the person who is tested, beyond that of the diagnosis. The result of VCT will also have implications for the baby, partner and family of an HIV-positive pregnant woman.

• A positive test result can lead to isolation and stigma because of misinformation, fear and prejudice surrounding HIV.

• Research has also shown that when women test and their partner’s or husband’s do not, if the woman tests positive, she may be blamed for introducing the infection in the couple, sometimes leading to violence or abandonment. Men should be encouraged to test along with their pregnant wife or partner when feasible.

• In addition to regular pre-test and post-test counseling, HIV-positive pregnant woman should be given appropriate information to make informed decisions about continuation of their
pregnancy and future fertility, treatments to prevent mother to child transmission (MTCT) during labor and delivery, and breastfeeding options.
PARTICIPANT HANDOUT:
ADVANTAGES AND DISADVANTAGES OF VCT

Advantages
• If an individual takes an HIV test and the result is negative, the person can be reassured that he or she did not have HIV three months before the test.
• Some people think they would feel better if they knew their HIV status, even if they are infected.
• If a person is infected with HIV, he or she can prevent infecting other sexual partners in the future.
• If a couple has been practicing safer sex, they may want to be sure that neither of them has HIV before they stop using condoms.
• Children born to women who have HIV stand a considerable risk of becoming infected during pregnancy, labor and delivery, and breastfeeding. Therefore, when a woman finds out that she is pregnant, she may want to have an HIV test so that she can decide on treatment and breastfeeding options to prevent MTCT.
• Some people want to know their HIV status so that if they are infected with HIV, they can make lifestyle changes that will help preserve their health and ensure that they live longer or better lives.

Disadvantages
• When an HIV test comes back positive, a client may not be able to handle knowing that he or she is infected with HIV. Before a person takes the test, he or she should think about how he or she will react to receiving such a result and about delaying the test.
• Before providing an HIV test, providers should discuss the possibility of a positive result with the client. He or she should be aware of the fact that being HIV-positive carries with it a lot of social stigma. Some HIV-infected people have been thrown out of their homes, fired from their jobs, victimized in their community, and physically assaulted. In addition, sometimes the children of HIV-infected parents are prevented from going to school.

Note: People should think through these possible problems before they make a decision to have a test. Many people with HIV choose to avoid some of these problems by keeping their test results secret. Unfortunately, because so many people do keep their test results secret, the community never knows how common HIV is and how extensively the illness affects them all. When members of a community think that HIV affects only a few individuals, they find it easier to stigmatize those with the disease and avoid the need to practice safer sex.
Factors influencing MTCT of HIV:
- MTCT of HIV is more likely to occur with advanced maternal disease and diminished immune status. Low CD4 counts or high viral loads may reflect this.
- Women who receive Zidovudine, AZT, or other antiretroviral drugs during pregnancy have lower rates of transmission, which is thought to be mainly the result of a reduction in viral load.
- MTCT can be reduced by giving Nevirapine to the mother at the onset of labor and to the newborn infant within 72 hours of birth.
- MTCT can also be reduced by avoiding breastfeeding. (Note: Breastfeeding is still recommended unless safe alternatives are affordable and feasible).
- If membranes rupture more than four hours before delivery, the risk of transmission appears to double.
- Cigarette smoking and maternal injection drug use have both been associated with an increased risk of MTCT.
- Women who have a high rate of unprotected sexual intercourse during pregnancy are more likely to transmit HIV. This may be due to increased concentration or strain diversity of HIV, or could be the effect of cervical or vaginal inflammation or abrasions.
- The presence of sexually transmitted infections during pregnancy has been associated with risk of transmission.
- Infections of the placenta may increase the risk of transfer of HIV.
- Suctioning of the newborn damages the newborn mucosal membrane and may increase MTCT risk.

Reducing Risk of MTCT:
- By giving Nevirapine at onset of labor and giving Nevirapine syrup to the baby within 72 hours of birth
- Antiretroviral therapy: long course of antiretrovirals (Zidovudine or combination), short course of antiretrovirals (Zidovudine or combination), or ultra short course of Nevirapine
- Elective caesarean section
- Replacement feeding for the infant (if safe alternatives are available and affordable)
- Restricted use of invasive obstetrical procedures (for example, amniocentesis)
- Avoiding external cephalic version in breeches
- Modifying infant feeding practices (exclusive breastfeeding with rapid weaning)
- The prevention of new HIV infections in women of reproductive age remains very important. This includes the reduction of women’s vulnerability to HIV infection through improvement of their status in society, the provision of information about HIV/AIDS and its prevention, promotion of safer sex and adequate treatment of sexually transmitted infections, together with behavioral change such as delaying the onset of first intercourse.

Risks of MTCT during labor/delivery:

- **The mode of delivery**
  Vaginal delivery has a higher risk of transmission than elective caesarean section delivery.

- **Prolonged rupture of membranes**
  Rupture of membranes for longer than four hours before delivery has been associated with an increased risk of transmission.

- **Episiotomy**
  Episiotomy may increase the risk of MTCT.

- **Intrapartum haemorrhage**
  Has been associated with increased transmission in some studies

- **Invasive fetal monitoring**
  Penetrating scalp electrodes may be associated with increased transmission risk.

- **Placental infection**
  Infection of the chorion or amnion may increase the risk of MTCT. (Genital infections, particularly sexually transmitted infections, may result in chorioamnionitis).

- **Twin deliveries**
  First twins have a higher rate of HIV infection than second born twins.

Risks of MTCT in Breastfeeding

- **Recent infection with HIV during pregnancy or during breastfeeding**
  A woman has higher levels of HIV (viral load) if she is infected during pregnancy or while breastfeeding.

- **AIDS**
  A woman who develops AIDS during pregnancy or while breastfeeding is more likely to transmit HIV infection to her infant.

- **Duration of breastfeeding**
  Most infections occur early in the breastfeeding period but the infant continues to be exposed to HIV as long as breastfeeding continues.

- **Severity of HIV infection**
  If the mother is ill with HIV-related disease or AIDS, she has more virus in her body and transmission to the baby is more likely.

- **Condition of breasts**
  Nipple fissure (especially if the nipple is bleeding), mastitis, or breast abscess may increase the risk of HIV transmission through breastfeeding.

- **Condition of the baby’s mouth**
  Mouth sores or thrush make it easier for the virus to go into the baby.
PARTICIPANT HANDOUT: 
BENEFITS AND DISADVANTAGES OF HIV VCT (VOLUNTARY COUNSELING AND TESTING) IN A MATERNITY SETTING*

Benefits:
- Knowledge of a negative result in pregnancy can reinforce safer sex practices and may help empower the pregnant woman to remain HIV negative.
- Knowing a woman’s HIV status would allow counseling on infant feeding practices. HIV-negative women would be encouraged to breastfeed exclusively, and HIV-positive women would have the option of minimizing the risk of HIV transmission by avoiding breastfeeding.
- Identifying HIV in pregnancy may enable women to access antiretroviral therapy to reduce MTCT of HIV.
- Knowledge of her HIV status may enable a woman to make informed choices about future fertility and pregnancies.
- A woman who knows she is HIV-infected may seek early appropriate medical care for HIV-related conditions such as tuberculosis, if she becomes ill.
- If a woman and her healthcare team are aware that she has HIV she can be referred for specialist medical help, or to non-governmental organizations (NGOs) for ongoing HIV care, plus emotional and social support.
- Diagnosis of HIV in the mother allows for the appropriate diagnosis, treatment and follow-up care of her baby.
- Women who have had an HIV test may be able to share their test result with their sexual partner/s. This can be important in encouraging partners to be counseled and tested.
- Widespread access to testing can help to destigmatize HIV in the community, as increasing numbers of people become aware of their status.
- Knowledge of their HIV-positive status might enable women to take part in peer support groups.
- Newly identified HIV-infected women can be helped to adopt a positive lifestyle.

Disadvantages
- HIV testing may create disharmony in the family.
- There may be an increase in the risk of abandonment or violence against women who test HIV-positive.
- It may cause blaming and the stigmatization of HIV-positive women by both the community and health workers.
- There may be an additional workload for maternity services and increased stress for healthcare workers carrying out counseling.
- It may create a need for additional space and privacy in busy health services.
- If there are no resources to provide interventions to reduce transmission to the infant, health workers and mothers may feel angry and frustrated.

PARTICIPANT HANDOUT:
SOCIAL VULNERABILITIES AND HIV/STI RISK*

Some factors that affect social vulnerability:
• Gender
• Economic power
• Youth
• Cultural factors
• Policies (related to legalization of sex work, condom availability, sex education, legalization of homosexuality, etc.)

Women and vulnerability to HIV/STIs:
Why are women more vulnerable to HIV infection?:
• Biologically:
  - Larger mucosal surface; micro-lesions which can occur during intercourse may be entry points for the virus; very young women even more vulnerable in this respect
  - More virus in sperm than in vaginal secretions
  - As with STIs, women are at least four times more vulnerable to infection; the presence of untreated STIs is a risk factor for HIV
  - Coerced sex increases risk of micro-lesions
• Economically
  - Financial or material dependence on men means that women cannot control when, with whom and in what circumstances they have sex.
  - Many women have to exchange sex for material favors, for daily survival. There is formal sex work but there is also this type of exchange, which in many poor settings, is many women's only way of providing for themselves and their children.
• Socially and culturally
  - Women are not expected to discuss or make decisions about sexuality.
  - They cannot request, let alone insist on using a condom or any form of protection.
  - If they refuse sex or request condom use, they often risk abuse, as there is a suspicion of infidelity.
  - The many forms of violence against women mean that sex is often coerced which is itself a risk factor for HIV infection.
  - For married and unmarried men, multiple partners (including sex workers) are culturally accepted.
  - Women are sometimes expected to have relations with or marry older men, who are more experienced, and more likely to be infected. In some places, men are seeking younger and younger partners in order to avoid infection and in the belief that sex with a virgin cures AIDS and other diseases.

**PARTICIPANT HANDOUT: POWER AND CONTROL WHEEL**

*Developed by the Domestic Abuse Intervention Project, 206 West 4th St., Duluth, MN. 55806, USA, [www.duluth-model.org](http://www.duluth-model.org)*
PARTICIPANT HANDOUT: SAFER SEX ACTIVITIES

- Talking to each other about safer sex
- Kissing and hugging
- Back rubs, foot massage, & body rubs while still partially dressed
- Listening to music/dancing together
- Stroking, brushing, or playing with each other’s hair
- Caressing, tickling, pinching & nibbling each other through clothes
- Reading erotic literature together
- Looking at erotic pictures together
- Watching erotic movies on the VCR
- Sharing sexual fantasies or talking sexy
- Dry humping
- Showering together
- Kissing or liking or fondling (except for genitals and anus)
- Undressing each other or watching each other undress
- Rubbing any non-petroleum-based body oil or lotion on each other or yourself
- Stroking, caressing, & fondling (including genitals and anus if there are no lesions)
- Mutual or simultaneous masturbation to orgasm with your hands (with or without condoms, if there are no lesions, and with no exchange of semen or vaginal fluids)
- Mutual or simultaneous masturbation using sex toys (without sharing)
- Rubbing genitals against healthy, unbroken skin on your partner’s body, making sure that men do not ejaculate in or on your partner’s body orifices
- Oral sex (fellatio) with a condom on
• Oral sex (cunnilingus) using a dental dam

• Vaginal or anal penetration with a sex toy (without sharing)

• Licking whipped cream, chocolate spreads or your favorite food off your partner’s body, except for unprotected body openings

• Masturbating while your partner watches or holds you

• Eating breakfast, lunch, or dinner in bed

• Holding each other

• Sleeping together
PARTICIPANT HANDOUT: WHAT IS SAFER SEX?

Introduction

Whether we are women or men, married or single, young or old, homosexual, heterosexual, bisexual or transgender, we are all sexual – from birth to death.

Most people have taken risks when they have had sex, perhaps without realizing it – risks that may result in STI transmission. People take so many risks, that at least one in four of us gets an STI at some point in our lives.

The risks people take can be dangerous. We know that safer sex reduces risk. Safer sex is about getting more pleasure with less risk.

There are three key steps to safer sex:
• Being able to assess the risks we take;
• Deciding which risks we are willing to take, and which ones we are not willing to take;
• Knowing how to do it.

Safer sex

Safer sex includes practices that reduce the risk of contracting STIs, including HIV infection. These practices reduce contact with the partner’s body fluids, including semen, vaginal fluids, blood, and other types of discharge from lesions or open sores.

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.

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, as well as oral-oral 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 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.

Safer sex practices help people protect themselves and others. Exploring safer sex can help to:
• Improve partner communication
• Increase intimacy and trust
• Prolong sex play
• Enhance orgasm
• Add variety to sexual pleasure
• Relieve anxiety
• Strengthen relationships

Note: Refer to the handout Safer Sex Activities (on page 47) for ideas and suggestions on non-penetrative sex.
PARTICIPANT HANDOUT: REDUCING CONDOM USER ERROR*

Misuse of the condom, rather than poor condom quality, accounts for the majority of breakage and slippage. Most users rarely experience breakage or slippage. Condom effectiveness depends heavily on the skill level and experience of the user.

Common errors with condoms that increase the risk of pregnancy and/or sexually transmitted infections include:

- **Failure to use the condom with every act of intercourse**
  Rather than breakage or slippage, non-use accounts for most pregnancies attributed to condom use.

- **Failure to use condoms throughout intercourse**
  Some men put condoms on after starting intercourse or may remove condoms before ejaculating, practices that raise the risks of pregnancy or STIs. In one study, men acquired gonorrhea despite condom use because they failed to put the condom on before starting intercourse. For condoms to be effective, they must be used every time from "start to finish."

- **Improper lubricant use with latex condoms**
  Unlike water-based lubricants (e.g., K-Y Jelly), oil-based lubricants (e.g., petroleum jelly, baby oil, and hand lotions) reduce latex condom integrity and facilitate breakage. Some people use oil-based products as condom lubricants, mistaking them for water-based lubricants because they readily wash off with water. Because vaginal medications (e.g., for yeast infections) often contain oil-based ingredients that can damage latex condoms, clients who are using or prescribed these medications should be advised to remain abstinent, use polyurethane condoms (if available), or use other contraceptives until the medication is fully completed and the infection is cured. **Note:** oil-based products may be safely used as lubricants with polyurethane condoms. See the list of safe and un-safe products below.

- **Incorrect placement of the condom on the penis.**
  Condoms may tear if clients are not careful when removing the condom from the package. Some men accidentally place the condom upside-down on the penis, then flip the condom over and use it for intercourse, a practice that may expose their partner to pre-ejaculatory fluid or infectious penile secretions. Although pregnancy is unlikely to result from exposure to pre-ejaculate, HIV has been detected in the pre-ejaculatory fluid of infected men. Whether the amount of HIV in pre-ejaculate is sufficient to cause infection has not been established. Incorrect placement can also cause air bubbles to be trapped inside the condom, which then cause breakage during intercourse. The air must be pinched out of the condom’s tip before putting it on.

- **Poor withdrawal technique**
  Slippage during withdrawal, one of the most common reasons for condom failure, may be prevented if the condom's rim is held against the base of the erect penis soon after ejaculation while withdrawing. One study found only 71 percent of men held the rim during withdrawal and only 50 percent withdrew immediately after ejaculation.

*From [www.youandaids.org](http://www.youandaids.org)
• **Failure to check expiration date and quality of condoms**
  Condoms should not be used after their expiration date (this is usually printed on the packaging). Users should check that condoms are sealed, there are no cracks or holes or any other damage.

• **Failure to store condoms properly**
  Heat damages condoms, therefore they should never be stored in hot places, for example, under direct sunlight or in pockets of tight jeans.
Description of the female condom

- It is a strong, loose-fitting polyurethane sheath about 17 cm (6 ½ inches) long, with a flexible ring at each end.
- Polyurethane is a soft, thin plastic that is stronger than latex, which is what is used to make most male condoms.
- Polyurethane conducts heat efficiently, so sexual behaviors can be more sensitive and pleasurable for both partners.
- Polyurethane is odorless, as is the lubrication that comes with the female condom.
- The inner ring is used to insert the female condom and helps keep the female condom in place. The inner ring slides in place behind the pubic bone.
- The outer ring is soft and remains outside the vagina during sexual intercourse. It covers the area around the opening to the vagina (vulva). This can also provide more pleasure for the woman because the ring often comes into contact with the clitoris during intercourse.

Advantages of the female condom

- There are no serious side-effects associated with the use of the female condom. Less than 10% of users report mild irritation.
- It can be inserted up to eight hours before a sex act, so it will not interrupt the sexual activity.
- The penis does not have to be erect when it is inserted into the female condom.
- It does not need to be removed immediately after ejaculation like the male condom does.
- It does not require a prescription or the involvement of a health care provider.

Special considerations

- It comes pre-lubricated with a non-spermicidal (spermicides kill sperm), silicone-based lubricant that is needed to ease insertion and movement during intercourse.
- Lubrication reduces noise during sexual intercourse (some users have reported some squeaking when using the female condom), and makes sex smoother.
- Additional lubricant, whether oil- or water-based, can be used.
- Male and female condoms should not be used together. Friction between the polyurethane and latex can result in either condom failing. In addition, if an oil-based lubricant is used with the female condom, it will cause the latex in the male condom to deteriorate.

PARTICIPANT HANDOUT:
INSTRUCTIONS FOR USING A FEMALE CONDOM*

1. Check the expiration or manufacture date on the package.

2. Open the package carefully; it should be torn at the notch at the top right of the package. Do not use scissors, a knife, or teeth to open the package.

3. Choose a position that is comfortable for insertion. This may be squatting, raising one leg, or sitting or lying down.

4. Look at the condom to make sure that it is lubricated.

5. While holding the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.

6. With the other hand, separate the outer lips of the vagina.

7. Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.

8. Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.

9. The female condom is now in place and ready for use with a partner.

10. When you are ready, gently guide your partner’s penis into the sheath’s opening with your hand to make sure that it enters properly. Be sure that the penis is not entering on the side, between the sheath and the vaginal wall. Use enough lubricant so that the condom stays in place during sex. If the condom is pulled out or pushed in, there is not enough lubricant. Add more to either the inside of the condom or the outside of the penis.

11. To remove the condom, twist the outer ring and gently pull the condom out. Try to do this before standing up to avoid any spilling of semen.

12. Wrap the condom in its package or in a tissue and throw it in the garbage.

PARTICIPANT HANDOUT: “I CAN’T ASK MY PARTNER TO USE CONDOMS BECAUSE…”
PARTICIPANT HANDOUT:  
RESPONDING TO EXCUSES FOR NOT USING CONDOMS*

1. “I can’t feel anything when I wear a condom.”
   Possible response: “I know there’s a little less sensation – but there’s not a lot less. Why don’t we put a drop of lubricant inside the condom – that’ll make it feel more sensitive.”  
   (Note: lubricants should be water-based)

2. “I don’t need to use a condom – I haven’t had sex in ___ months, so I know I don’t have any diseases.”
   Possible response: “That’s good to know. As far as I know, I’m disease-free, too. But I’d still like to use a condom because either of us could have an infection and not know it.”

3. “If I have to stop and put it on, I won’t be in the mood anymore.”
   Possible response: “I can help you put it on. That way, you’ll continue to be aroused, and we’ll both be protected.”

4. “Condoms are messy, and they smell funny.”
   Possible response: “It’s really not that bad. And sex can be a little messy sometimes. But this way, we’ll be able to enjoy it and both be protected from pregnancy and HIV/STIs.”

5. “Let’s not use condoms just this once.”
   Possible response: “No. Once is all it takes to get pregnant or get an infection.”

6. “I don’t have a condom with me.”
   Possible response: “That’s okay. I do.”

7. “You never asked me to use a condom before. Are you having an affair?”
   Possible response: “No. I just think we made a mistake by never using condoms before. One of us could have an infection and not know it. It’s best to be safe.”

8. “If you really loved me, you wouldn’t make me wear one.”
   Possible response: “If you really loved me, you’d want to protect yourself – and me – from infections and pregnancy so that we can be together and healthy for a long time.”

9. “Why are you asking me to wear a condom? Do you think I’m dirty or something?”
   Possible response: “It’s not about being dirty or clean. It’s about avoiding pregnancy and the risk of infection.”

10. “Only people who have anal sex need to wear condoms, and I’m not like that.”
   Possible response: “That’s not true. A person can get an infection during any kind of sex, including what we do together.”

11. “Condoms don’t fit me.”
   Possible response: “Condoms can stretch a lot – in fact, they can stretch to fit over a person’s head! So we should be able to find one that fits you.”

12. “Why should we use condoms? They just break.”
   Possible response: “Actually, they told me that condoms are tested before they’re sent out – so while they have been known to break, it happens rarely, especially if you know how to use one correctly and I do.”

13. “What happens if it comes off? It can get lost inside you, and you’ll get sick, or could even die. Do you want that?”
   Possible response: “It’s impossible for the condom to get lost inside me. If it came off, it’d be inside my vagina, and I could just reach in and pull it out.”

14. “If you don’t want to get pregnant, why don’t you just take the birth control pill?”
   Possible response: “Because the birth control pill only protects against pregnancy. The condom protects against both pregnancy and infections.” or “Because I discussed my options with a doctor and we decided that condoms are the best method for me to prevent pregnancy.”

15. “My religion says that using condoms is wrong.”
   Possible response: “It might help to talk with one of your religious leaders. A lot of people from different religions use condoms, even though their religion is against it. They figure that preventing infection or unintended pregnancy is more important than worrying about the morality of condoms.”

16. “Well, I’m not going to use a condom, and that’s it. So let’s have sex.”
   Possible response: “No. I’m not willing to have sex without a condom.”

17. “No one else uses them. Why should we be so different?”
   Possible response: “Because a lot of people who didn’t use them ended up with HIV.”

18. “You’re a woman. How can you possibly ask me to use a condom? How can I respect you after this?”
   Possible response: “You should respect me even more because I am acting responsibly. I’m suggesting this because I care about you and respect myself enough to protect myself. That’s enough for me.”
PARTICIPANT HANDOUT: INTRODUCTION TO DUAL PROTECTION*

What is dual protection?
Dual protection can be defined as a strategy to prevent both HIV/STI 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. More specifically, dual protection can include:

1) The use of condoms alone:
   • The use of a condom (male or female) alone for both purposes.

2) 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, should the condom fail;
   • Selective condom use plus another family planning method (for example, using the pill with a primary partner but the pill plus condoms with secondary partners).

3) The avoidance of risky sex:
   • Abstinence
   • Avoidance of all types of penetrative sex
   • Mutual monogamy between uninfected partners combined with a contraceptive method for those wishing to avoid pregnancy
   • Delaying sexual debut (for young people)

Why is condom promotion so important for dual protection?
• The male latex condom, when used correctly and consistently, is the only technology that has been proven to be highly effective in preventing the sexual transmission of HIV and pregnancy at the same time.
• The female condom may be as effective but there is not enough data to support this claim at this time.

Why is it important to legitimize condoms as an effective method of family planning?
• In some cases, pregnancy prevention can be a greater motivator for condom use than HIV/STI prevention.
• If family planning programs promoted condoms as an effective method for pregnancy prevention, this would have the added benefit of reducing the stigma of the condom as a method to prevent only HIV/STIs.
• In general, many family planning providers believe that condoms are not effective for pregnancy prevention, but they are effective for HIV/STI prevention. In part, this bias is based on the fact that some other family planning methods such as sterilization, IUDs, injectables and implants are more effective than condoms in “perfect” and “typical” use. But if condoms are used correctly and consistently, they are highly effective against pregnancy. This fact needs to be communicated to providers and clients alike.

* Adapted from Condom Promotion and Dual Protection, Jeff Spieler, Mihira Karra and Kirsten Vogelsong, USAID/G/PHN/POP/R; and PRIME II slide show
• Data show that from a single act of unprotected penile-vaginal intercourse, the probability of acquiring various STIs is much greater than becoming pregnant. Therefore if condoms are used consistently and correctly to prevent STIs, then they must be even more effective against pregnancy.

• Condoms and those who use them are stigmatized because they are currently associated with HIV/STI prevention and their use implies that partners may have other sexual partners. This stigma from associating condom use and sex work or sexual promiscuity can be addressed by promoting condoms as effective methods for both pregnancy and disease prevention.

Why is dual protection counseling so important in family planning services?
• Many family planning clients may be at risk of infection with HIV/STIs as well as unintended pregnancy. Many women are at risk of HIV/STIs mostly as a result of their partners’ risky behaviors. Dual protection counseling can help clients to perceive their own risk of infection and unintended pregnancy and to 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 HIV/STI prevention needs are inseparable and should be addressed together.

How does dual protection counseling relate to the concept of “informed choice”?
• Dual protection counseling upholds the concept of informed choice by making sure that clients’ are knowledgeable and aware of their risks for HIV/STI prevention 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 HIV/STIs and knowledgeable about how effective the various family planning methods are in preventing HIV/STIs. Dual protection counseling ensures that clients are aware, knowledgeable and informed.

What are some key strategies for dual protection in a family planning setting?
• 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 palatable to both partners.

• Helping women to consider the ramifications of their decisions – both positive and negative, and recognizing the limitations that many women may have in negotiating condom use (i.e., insisting on condom use may lead to violence, abandonment, etc.).

• Promoting the female condom as a viable method (where it is available).
Case study 1

Sarah is a 25-year old married woman who comes to the family planning clinic to discuss family planning methods with a counselor. She and her husband have 3 young children and they want to wait a little while before having a fourth child. After waiting about an hour, she meets with Anita, a family planning counselor. Anita warmly welcomes Sarah to the clinic and inquires why she has come to the clinic. Sarah replies that she is interested in learning more about family planning and wants to wait before having a fourth child. Anita asks Sarah what she knows about family planning, and which methods she is familiar with. Sarah tells her that she has never used family planning herself but that some of the women in the village have used the pill, the IUD and injectables.

Anita takes out a printed flipchart that has a page on each of the major methods that the clinic provides – oral contraceptives, the IUD, injectables, vasectomy, tubal ligation and condoms. Anita goes through the flipchart page by page and explains each of the methods to Sarah, stopping to answer any questions that Sarah has. When Anita gets to the page on condoms, she goes through it quickly and mentions that Sarah probably wouldn’t be interested in condoms because they are not quite as effective as the other methods, and besides most married people aren’t interested in them. After hearing Anita’s presentation about the different methods, Sarah indicates that she is interested in the pill. Anita shows her a packet of pills and explains how to use them in depth. She also addresses what Sarah should do if she misses one or two, etc. After briefly screening Sarah for any contraindications for the pill, Anita gives Sarah two packets of pills and tells her to come back in two months for a follow-up visit and to purchase more pills.
Case study 2

Layla is a 32-year old married woman who has come for VCT services at a local VCT center because she has reason to fear that her husband may be infected with HIV. Her husband travels frequently for work and it is no secret that he has sex with many other women while he is on the road. She doubts that he uses condoms with any of his partners. Layla is scared to come to the VCT center, but she wants to find out if she is infected with HIV. Layla first meets with a VCT counselor named Marjorie for pre-test counseling. She comes back to the VCT clinic in two weeks to receive her test results. Layla is much relieved to find out that her test result is negative. When Layla meets with Marjorie for post-test counseling, Marjorie asks Layla about how she perceives her risk of becoming infected with HIV. Layla mentions her fears and concerns about her husband’s behavior when he is traveling. Marjorie asks Layla if she has ever used condoms. When Layla says that she hasn’t, Marjorie asks how she thinks that her husband would feel about using them. Layla thinks that he would be opposed to using them, and probably would be angry and offended if Layla asked him to.

Marjorie acknowledges that it can be difficult to talk to your husband about condoms, and then talks to Layla about the benefits of the condom (male and female) and mentions that it is the only method that provides effective protection against HIV/STIs. She shows Layla a male condom and does a demonstration on how to use one on a wooden penis model. She asks Layla to practice putting a condom on the model after showing her how to do it. Layla practices putting on the condom and asks Marjorie some questions about condoms, to which she responds. Marjorie talks about how couples’ can make condoms a part of their sex life and some of the sexual benefits of using condoms – a man can last longer, protection against HIV/STIs can make people feel safer and therefore more pleasure, etc. Layla is a little embarrassed by Marjorie talking about sex, but Marjorie reassures her that she talks about it with everyone and that she wants to help people feel more comfortable about and interested in using condoms. Marjorie and Layla discuss strategies that Layla can use to bring up the subject of condoms with her husband, and they role play a discussion with Layla playing herself and Marjorie playing the part of the husband. They conclude the counseling session by discussing Marjorie’s options for protecting herself from HIV and making a plan about how she will bring up condom use with her husband. Marjorie gives her some condoms and invites her to come back for follow-up in a few weeks.
VOLUME 2

SECTION THREE: INTEGRATED COUNSELING SKILLS BUILDING

(PARTICIPANT HANDOUTS)
PARTICIPANT HANDOUT: INTEGRATED DUAL PROTECTION COUNSELING FRAMEWORK (long version)

Note: The bullets below are points that should be included within an interactive discussion with the client, as appropriate to the client’s situation. They are not meant as a checklist to follow in strict order, nor are they to be read or recited to the client.

STEP ONE: Introductions

1. Welcoming the client
   • Greet the client warmly

2. Introductions
   • Identify the reason for the client’s visit
   • Ask general questions such as name, age, number of children, etc.

3. Assuring confidentiality
   • Make the client feel comfortable by assuring confidentiality

4. Helping the client to relax and feel comfortable

STEP TWO: Exploration

1. Exploring clients’ needs, risks, sexual lives, social context and circumstances
   • Explore the context of clients’ sexual relationships:
     a. What sexual relationships are they in, what is the nature of the relationships (including any violence or abuse), and how do they feel about it?
     b. How do they perceive their sexual pleasure and sexual problems?
     c. How do they characterize their ability to communicate with partners about sexuality, family planning and HIV/STIs?
     d. What is their knowledge about partners’ sexual behaviors outside of their relationship?
   • Explore clients’ STI history and present symptoms and knowledge of partners’ STI history, HIV testing history and knowledge of partners’ HIV status
   • Explore clients’ pregnancy history and knowledge of and use of family planning methods, including condoms, and their future pregnancy intentions.
   • Explore other factors about the client’s circumstances that may limit power or control over decision-making such as financial dependence on partners, tensions within an extended family, fear of violence, etc.
   • Explore clients’ sources of support in their families and/or communities.
   • Explore clients’ current family situation – number of children, living situation, extended family, social networks.
   • Explore clients’ current work situation.
   • Explore clients’ overall health situation.
2. Providing information about HIV/STI transmission and prevention and/or pregnancy prevention and dual protection
   • Explore clients’ knowledge of HIV, STIs, family planning and dual protection, and fill in gaps.
   • Briefly discuss the various family planning options, including their effectiveness for both HIV/STI and pregnancy prevention.
   • Explain HIV/STI transmission and pregnancy risks relating it to clients’ and their partners’ individual sexual practices (making sure to discuss the risks of a variety of sexual practices).
   • Discuss the importance of condoms as the only method that protects against both pregnancy and HIV/STI transmission when used correctly and consistently, and describe other options for dual protection and/or safer sex (i.e., non-penetrative sex, mutual monogamy plus a contraceptive method, dual method use, etc.).
   • Explain HIV testing and talk with clients about their interest in getting tested, if available.

3. Assisting clients to perceive or determine their own risk for HIV/STI transmission and/or unintended pregnancy
   • Ask clients if they feel that they might be at risk for HIV/STI transmission.
   • Ask clients if they think that their partners may be at risk for HIV/STI transmission and explore the reasons.
   • Help clients to articulate, recognize and acknowledge their risks for HIV/STI transmission and/or unintended pregnancy.

STEP THREE: Decision-making

1. Discussing dual protection, HIV/STI prevention and/or pregnancy prevention options
   • Make sure that discussion centers on options that are appropriate to clients’ individual needs, taking into account the client’s pregnancy and HIV/STI prevention priorities.
   • For those methods that the client seems interested in, provide more detailed information on how to use the method, potential side effects, potential impact of the method on sexual relations, and how it may or may not reduce any of the HIV/STI risks that the client identified.
   • Help clients to choose methods or dual protection options that meet their needs.
   • Help clients make decisions about HIV testing, if available, either on-site or in another location.

2. Assisting clients to make realistic decisions
   • Help clients to assess whether their decisions are feasible given their relationships, family life, economic situation, etc.
   • Brainstorm with clients how to overcome potential barriers to carrying out decisions.
3. **Helping clients to anticipate the potential outcomes (positive or negative) of their decisions**
   - Assist clients to identify possible outcomes of actions that they make choose to take.
   - Explore with clients how they think that partners may react to actions that they may choose to take (i.e., suggesting condom use, discussing sexuality with partners, getting an HIV test).

4. **Discussing risk reduction options**
   - Help clients to determine incremental steps that they can take over time to reduce their risks.
   - Help clients to consider other risk reduction options when they are unable to negotiate or communicate with partners, such as indirect communication or avoiding risky situations.
   - Discuss community resources that may help in supporting the client to reduce risk, such as women’s empowerment groups, etc.

**STEP FOUR: Skills-building for action**

1. **Developing partner communication and negotiation skills**
   - Discuss clients’ fears or concerns about communicating and negotiating with partners about dual protection, condom use, family planning, HIV testing or sexuality and offer ideas for improving communication and negotiation.
   - For those clients who feel it may be difficult to negotiate condom use for HIV/STI prevention purposes, discuss whether it might be easier to introduce condoms for pregnancy prevention purposes.
   - Role play with the client possible communication and negotiation situations that may occur.

2. **Developing condom use skills**
   - Demonstrate correct condom use on a penis model, describing the steps, and ask clients to repeat the demonstration to assure they understand.
   - Discuss strategies for eroticizing condom use and making condoms more appealing to clients and their partners.
   - Provide samples of condoms to clients (if possible) and make sure they know where and how to obtain more.

3. **Developing other family planning method use skills**
   - Make sure that clients understand how to use other family planning methods that they have selected by repeating back basic information and encouraging them to ask for clarification.

4. **Developing a plan for carrying out decisions**
   - Develop a plan of action for implementing HIV/STI risk reduction and pregnancy prevention, which addresses specific steps such as obtaining a supply of condoms and/or another family planning method, negotiating with partners, etc.
• Invite clients back for a follow-up visit to provide ongoing support with decision-making, negotiation and condom use.

5. **Making referrals to community resources to support clients in realizing decisions**
• Make referrals to community resources that may help clients meet their pregnancy/HIV/STI risk reduction goals or address other needs raised during the counseling session (such as the desire to get an HIV test).
PARTICIPANT HANDOUT: INTEGRATED DUAL PROTECTION COUNSELING FRAMEWORK (short version)

STEP ONE: Introductions
1. Welcoming the client
2. Introductions
3. Assuring confidentiality
4. Helping the client to relax and feel comfortable

STEP TWO: Exploration
1. Exploring clients’ needs, risks, sexual lives, social context and circumstances
2. Providing information about HIV/STI transmission and prevention and/or pregnancy prevention and dual protection
3. Assisting clients to perceive or determine their own risk for HIV/STI transmission and/or unintended pregnancy

STEP THREE: Decision-making
1. Discussing dual protection, HIV/STI prevention and/or pregnancy prevention options
2. Assisting clients to make realistic decisions
3. Helping clients to anticipate the potential outcomes (positive or negative) of their decisions
4. Discussing risk reduction options

STEP FOUR: Skills-building for action
1. Developing partner communication and negotiation skills
2. Developing condom use skills
3. Developing other family planning method use skills
4. Developing a plan for carrying out decisions
5. Making referrals to community resources to support clients in realizing decisions
PARTICIPANT HANDOUT: THE DUAL PROTECTION GATHER APPROACH

G → GREET
- Greet the client politely and warmly.
- Praise the client for coming in.
- Explain that the discussion is confidential and discuss the clinic’s confidentiality policy, if applicable.
- Build “rapport” with a client by developing feelings of safety and trust so that clients will feel comfortable talking with the provider about their sexual and reproductive health concerns, particularly issues related to HIV/STIs, sexuality and dual protection (for HIV/STIs and pregnancy).

A → (ASSESS) ASK
- Ask the client about her or himself, family members, and general life circumstances.
- Ask the client why she or he has come to the clinic.
- As the client gives you information about why she or he has come in, ask probing questions as part of the assessment process. (Make the client aware that you ask these questions of all clients to best meet their sexual and reproductive health needs.)
- Ask about the client’s current sexual life (and behaviors) and sexual history:
  - What he or she knows about his or her partner’s sexual behaviors
  - What he or she knows about HIV/STIs, what he or she knows about family planning
  - What he or she knows about condoms
  - If he or she has ever been tested for HIV
  - If he or she perceives himself or herself to be at risk of infection with HIV/STIs, unintended pregnancy, and/or violence
  - If he or she has other sexual health concerns

T → (TALK) TELL
- Tell the client about:
  - What kinds of services the clinic offers
  - Options for family planning and dual protection
  - Basic information about each family planning method, including how well they prevent HIV/STIs as well as pregnancy and how they may impact sexuality
  - Ways of preventing HIV/STI, with an emphasis on condom use
  - Basic information about voluntary counseling and testing for HIV
- The amount and extent of the information will have to be determined by the counselor on a case-by-base basis.
- Apply information about HIV/STI transmission and risk as well as pregnancy to the client’s individual situation and needs to help him or her perceive any risks.
H → HELP

- Help the client to make a decision that is best for her or him, including developing a plan for reducing risk of HIV/STIs and/or unintended pregnancy. This does not mean making the decision for the client. It means helping the client to determine if he or she is at risk for HIV/STIs and/or unintended pregnancy, and helping the client decide what he or she will do to reduce these risks.
- This may involve helping a client to select a family planning method, keeping in mind potential HIV/STI risk and the impact of the method on sexuality.
- It may involve working with a client to anticipate partner reaction, including a negative reaction or violence to introduction of condoms or discussion of sexuality or STI risk behaviors.
- It may involve weighing the costs and benefits of introducing condoms.
- If condom use is not feasible, it may include discussion of risk reduction strategies (withdrawal, leaving condoms where male partners will find them, etc.).
- It may involve helping a client make a decision about whether or not to get an HIV test.

E → EXPLAIN

- Explain whatever needs explanation or clarification:
  - How the clinic works
  - How a family planning method works
  - How a method may affect sexuality
  - How condoms are effective for dual protection
  - How STIs can be prevented
  - How any medication needs to be taken
  - How voluntary counseling and testing for HIV works and what HIV test results mean, etc.
- Demonstrate how to use a condom using a penis model and have the client practice.
- Explore how the client will follow through on a plan to reduce risk for HIV/STIs and/or unintended pregnancy.
- Explore how the client will confront and address obstacles. If applicable, role play ways to negotiate condom use or to talk to partners about sexuality, condom use, STI risk reduction or HIV testing.
R → (REFER) Schedule a RETURN visit.

• Whenever possible, schedule follow-up visits with clients to assess ongoing progress in carrying out their plan for reducing risk, and to make changes in the plan if necessary.
• Provide additional information, resources, and/or referrals as needed (for VCT, HIV care and support, STI screening, STI treatment, etc.)
SERVICE PROVIDER: Alicia?

CLIENT: I am Alicia.

SERVICE PROVIDER: Hello, I am Maria, I am a nurse at this clinic. Please sit down and make yourself comfortable. [pause] Why have you come today?

CLIENT: I am interested in getting a birth control method.

SERVICE PROVIDER: OK, Have you ever used family planning?

CLIENT: Well, we usually just avoid having sex during the middle of my cycle.

SERVICE PROVIDER: OK, what do you know about other family planning methods?

CLIENT: Well, my sister uses the pill, so I guess that would be a good method for me. I have also heard about something about the IUD from a friend.

SERVICE PROVIDER: What do they say about these methods?

CLIENT: My sister likes the pill very much, although she has gained some weight, and I don’t really know much about the IUD.

SERVICE PROVIDER: Well, I would like to explain some more to you about these methods, and also show you the other contraceptive methods that we have so that you can decide which one you prefer. First, I would like to ask you a few questions.

SERVICE PROVIDER: Hmmm . . . I see from your record that you have two children, one that is a baby, and one that is five. Are you breastfeeding?

CLIENT: No, not any more.

SERVICE PROVIDER: Do you have any plans to have more children?

CLIENT: Well, my husband and I have not discussed this, but I think we want to have one more in a few years, when our youngest is in school. I have two girls and my husband wants to have a boy.

SERVICE PROVIDER: You mentioned that you are interested in the pill?

CLIENT: Yes, I think I would like the pill. I would not mind gaining weight.
SERVICE PROVIDER: What do you know about the pill?
CLIENT: I know that it prevents pregnancy and you should take one pill every day.

SERVICE PROVIDER: Yes that is correct. [holding a package of pills and referring to chart showing family planning methods] The pill contains hormones that are the same hormones that are present in you body when you are pregnant. The pill works by tricking your body into thinking that you are pregnant. As you may know, when you are pregnant, your ovaries do not release an egg.

Some of the advantages of the pill are that you can take it at a specific time every day and you do not have to worry about remembering when you are ready to have sex; you can stop it at any time, and become pregnant again almost immediately after you stop taking it; it might also make your periods lighter and shorter and more regular; and offers some protection against cancer of the ovary and uterus.

CLIENT: I like the fact that it will make my periods more regular.

SERVICE PROVIDER: Yes, many women like that. However, there are some disadvantages that you should also know about. Like all contraceptives, it might have some side effects. Some women who use the pill experience some dizziness, nausea, mild headaches and weight gain. These are not serious and usually only occur during the first three months of use.

CLIENT: Hmm . . .

SERVICE PROVIDER: Do you think that you will be able to tolerate these side effects?

CLIENT: Well . . . it depends on how bad they are.

SERVICE PROVIDER: It is hard to predict if you will get them, or how bad they will be. If you do get them, and they become too much for you we can always try another method.

CLIENT: OK.

SERVICE PROVIDER: Now . . . Let me explain to you how to use the pill. You take one pill every day for as long as you do not want to become pregnant. You start taking your pill during the first five days of your menstrual cycle. You are having your period now, so you can start now. You take one pill everyday, at about the same time. Pick a time of day where you do something everyday like brushing your teeth or something like that. It is important that you take one pill everyday, even the brown pills. When you finish a cycle you continue on with the next one.

If you miss a pill take that pill as soon as you remember, even if it means taking two pills on the same day. If you miss two pills, you should take two pills for two consecutive days and use a back-up method, like condoms for 14 days.
CLIENT: OK.

SERVICE PROVIDER: Now, I would like to tell you about the other family planning methods we have available.

This is the IUD, which you mentioned. It is a method you can insert just once, and leave it in place for up to five years. It is a great method for some people because you don’t have to worry about remembering anything. The nurse or the doctor inserts it in your uterus like this [holds up a model], and a small string hangs out into your vagina. You can check to make sure the string is still there by feeling it. Since you have already had a child, the IUD could be a good method for you, but we would need to make sure that you are not pregnant before putting it in. Some people experience longer and heavier periods, bleeding between periods or cramps or pain during their periods.

[SERVICE PROVIDER BREAKS CHARACTER AND INDICATES TO THE AUDIENCE THAT SHE WOULD THEN GO ON TO DESCRIBE ALL OF THE OTHER FAMILY PLANNING METHODS AVAILABLE USING AN ANATOMY CHART, MODELS AND SHOWING SAMPLES OF THE METHODS]

SERVICE PROVIDER: Alicia, do you still want the pill, or is there another method that interests you?

CLIENT: Well, since my sister takes the pill, I guess it is a good method for me.

SERVICE PROVIDER: OK. I already explained the side effects to you, and as I said they are not medically serious. However, there are some warning signs that indicate serious medical problem. If you should have abdominal pain, chest pain or difficulty breathing, severe headache, blurred vision or difficulty seeing, or severe leg pain please come back right away. If it is on a weekend when we are closed go directly to the hospital.

CLIENT: Alright.

SERVICE PROVIDER: I will give you a packet of pills please come back to see me on October 10th and I will give you more. Do you understand every thing I have told you?

CLIENT: Yes

SERVICE PROVIDER: Good. Why don’t you repeat for me all of the instructions I gave you so we can make sure.

CLIENT: I should take one pill everyday. If I miss a pill, I should take that pill as soon as I remember it, even if it means taking two pills on the same day.

SERVICE PROVIDER: What do you do if you miss two pills?
CLIENT: If I miss two pills, I should take two pills for two consecutive days and use condoms for 14 days.

SERVICE PROVIDER: That’s correct. What are the warning signs?

CLIENT: If I have any severe problems like pain, trouble breathing, eye problems, severe headaches, or pains in the legs I should come back here or go to the hospital if you are not open.

SERVICE PROVIDER: That’s correct. You are ready to go. Do you have any other questions?

CLIENT: No.

SERVICE PROVIDER: I will see you on the 10th of October. Goodbye.

CLIENT: Goodbye.
PARTICIPANT HANDOUT:  
ALICIA VISITS A FAMILY PLANNING CLINIC (CASE STUDY VERSION 2: INTEGRATED DUAL PROTECTION COUNSELING FRAMEWORK VERSION)

SERVICE PROVIDER: Alicia?

CLIENT: I am Alicia.

SERVICE PROVIDER: Hello, I am Maria, I am a nurse at this clinic. [smiles] Please sit down and make yourself comfortable. [pause] Why have you come today?

[STEP ONE: INTRODUCTIONS: Counselor welcomes the clients warmly, introduces herself, inquires about the reason for the client’s visit]

CLIENT: I am interested in getting a birth control method.

SERVICE PROVIDER: OK, Have you ever used family planning?

[STEP TWO: EXPLORATION: Counselor explores client’s use of family planning]

CLIENT: Well, we usually just avoid having sex during the middle of my cycle.

SERVICE PROVIDER: OK, what do you know about other family planning methods?

[STEP TWO: EXPLORATION: Counselor explores client’s knowledge of family planning]

CLIENT: Well, my sister uses the pill, so I guess that would be a good method for me. I have also heard about something about the IUD from a friend.

SERVICE PROVIDER: What do they say about these methods?

[STEP TWO: EXPLORATION]

CLIENT: My sister likes the pill very much, although she has gained some weight, and I don’t really know much about the IUD.

SERVICE PROVIDER: Well, I would like to explain some more to you about these methods, and also show you the other contraceptive methods that we have so that you can decide which one you prefer. First, I would like to ask you a few questions. Hmmm . . . I see from your record that you have two children, one that is a baby, and one that is five. Are you breastfeeding?

[STEP ONE: INTRODUCTIONS: Counselor asks general questions]

CLIENT: No, not any more.

SERVICE PROVIDER: Do you have any plans to have more children?
CLIENT: Well, my husband and I have not discussed this, but I think we want to have one more in a few years, when our youngest is in school. I have two girls and my husband wants to have a boy.

SERVICE PROVIDER: You mentioned that you are interested in the pill?

CLIENT: Yes, I think I would like the pill. I would not mind gaining weight.

SERVICE PROVIDER: What do you know about the pill? [STEP TWO: EXPLORATION: Counselor explores client’s knowledge of a family planning method]

CLIENT: I know that it prevents pregnancy and you should take one pill every day.

SERVICE PROVIDER: Yes, that is correct. The pill is very good for protection against pregnancy, but did you know that it does not provide any protection against sexually transmitted infections including HIV? Why don’t you tell me what you know about STIs and HIV? [STEP TWO: EXPLORATION: Counselor explores client’s knowledge of HIV/STIs]

CLIENT: Well, I know that AIDS is deadly. I know that people who have a lot of different sex partners and people who use drugs can get it. I know that you can have it for a long time without knowing, and it takes a long time before you actually get sick. As for STIs, well, I have heard of syphilis and some others, but I don’t know much about them.

SERVICE PROVIDER: Good, you already know a lot about AIDS. I just want to clarify a few things. First, AIDS is caused by a virus called HIV. Not only drug users and people with a lot of sex partners can get it. Anyone can get it if they have sex with a person who is infected without using a condom, even if they do not look sick. So, just to review, there are three ways a person can get HIV. The first is through unprotected sex, that is, vaginal sex, oral sex or anal sex. You can also get other STIs through these same types of sex. The second is through blood, which you can get through used injection needles or through contaminated blood transfusions. And third, an infected mother can transmit the virus to her child during pregnancy, birth or breastfeeding. [EXPLAIN TO THE AUDIENCE THAT THE PROVIDER GIVES SOME MORE INFORMATION ON STIs].

As of now, there is no cure for HIV or AIDS. Our best defense is preventing HIV transmission by minimizing the number of partners we have, and using condoms whenever possible. [STEP TWO: EXPLORATION: Counselor explores client’s knowledge of HIV/STIs, gently corrects misinformation and fills in the gaps in knowledge]

As you may know sexually transmitted infections and HIV are a big problem here. Before I tell you more about the family planning methods, I would like to talk with a bit more about your personal life, if I may, to try and get some idea if these are things we should consider when making a decision about a family planning method, or to see if you have other, related concerns.
These are questions that I ask of all clients in order to meet their needs for health care. Your responses are strictly confidential and will not be shared with anyone else. Is that okay?

**[STEP ONE: INTRODUCTIONS: counselor makes the client feel comfortable by assuring confidentiality; explains that these questions are asked of all clients]**

CLIENT: I guess so...

SERVICE PROVIDER: You said that you are married, right? Is your husband the only sexual partner you have right now?

**[STEP TWO: EXPLORATION: Counselor explores the context of client’s sexual relationships]**

CLIENT: Yes, of course.

SERVICE PROVIDER: How long have you been together?

**[STEP TWO: EXPLORATION]**

CLIENT: A couple of years.

SERVICE PROVIDER: How is your relationship?

**[STEP TWO: EXPLORATION]**

CLIENT: Well, you know how it is.

SERVICE PROVIDER: You told me that you do not have any other partners right now, but have you had any other partners in the last 5 years or so?

**[STEP TWO: EXPLORATION]**

CLIENT: Yes, I was with somebody else before my husband, the father of my first child.

SERVICE PROVIDER: Have you ever thought about whether your husband might have other partners?

**[STEP TWO: EXPLORATION: Counselor explores the context of client’s sexual relationship by inquiring whether she thinks that her partner has other sexual partners]**

CLIENT: Well….my husband spends too much time away from home….he says he is taking care of business, but sometimes I wonder…

SERVICE PROVIDER: Is it possible that he has other women when he is away from home?

CLIENT: He probably does…that’s what my sister-in-law told me. I try not to think about it.

SERVICE PROVIDER: Do you think he wears condoms with other women?

**[STEP TWO: EXPLORATION]**
CLIENT: No, he hates condoms.

SERVICE PROVIDER: Have you ever thought about whether you are at risk of becoming infected with HIV or another sexually transmitted infection, like gonorrhea or syphilis?

[STEP TWO: EXPLORATION: Counselor assists client to perceive or determine her own risk for HIV/STIs]

CLIENT: No, not really. I wasn’t worried in the past because I trusted my previous boyfriend, but now that you are asking me these questions about my husband, I am starting to become worried that he could pass something to me.

SERVICE PROVIDER: Have you ever talked to him about HIV, STIs, about his relationships with other women or about your sex life in general?

[STEP TWO: EXPLORATION: Counselor explores client’s ability to communicate with her partner]

CLIENT: No, we never talk about those types of things.

SERVICE PROVIDER: Have you or your husband ever had any infections in the past, like discharge or a sore on your genitals?

[STEP TWO: EXPLORATION: Counselor explores client’s and partner’s STI history]

CLIENT: Well, I had an infection once, discharge, and the doctor gave me treatment, but I don’t know what it was.

SERVICE PROVIDER: Well Alicia, you are right to be concerned about STIs, and it is difficult for me to know whether the infection you had was an STI or whether it was another type of infection. But, if you ever have anything like that in the future, an unusual discharge, pain when you have sex, unusual pain in your lower abdomen, irritation, a blister or a sore on your genitals, it is important to come into the clinic to get it checked out. Also, if your husband has any of these symptoms, you should also get checked yourself because some STIs don’t show symptoms for quite a while in women, but they could be doing damage. [EXPLAIN TO THE AUDIENCE THAT THE PROVIDER ALSO GIVES INFORMATION ON VOLUNTARY COUNSELING AND TESTING FOR HIV.]

[STEP TWO: EXPLORATION: Counselor provides information about STI transmission and treatment and HIV testing, relating the information to the client’s and partner’s situation]

CLIENT: I will.

SERVICE PROVIDER: How would you feel if your husband used condoms?

[STEP TWO: EXPLORATION]

CLIENT: I think I would feel better, but how could I get him to use them? We don’t talk about those types of things.
SERVICE PROVIDER: Well, the most important thing is to talk with him. How do you think he would react if you brought up the subject?

STEP THREE: DECISION-MAKING: Counselor helps client to anticipate potential outcomes of decisions by exploring how she thinks her partner will react

CLIENT: I am worried that he might accuse me of having an affair or something.

SERVICE PROVIDER: Well, you might want to try to find a time and place when there are no other distractions, and try to bring up the subject in a way that doesn’t make him angry, maybe when he is in a good mood. You can read this booklet with him as a way to bring up the subject. Do you think that would work?

STEP FOUR: SKILLS-BUILDING FOR ACTION: Counselor discusses client’s fears and concerns about communicating and negotiating with partner and offers ideas for improving communication

CLIENT: Well, I can try.

SERVICE PROVIDER: Well, if that really doesn’t work, maybe you can figure out a way to try to encourage him to use condoms with other partners, if he does have them. You might try a subtle approach like leaving condoms in his drawer or his pocket.

STEP THREE: DECISION-MAKING: Counselor discusses risk reduction options such as leaving condoms where male partners will find them

CLIENT: [Laughs] Well, I’ll think about that, too.

SERVICE PROVIDER: Well, if it goes well, you can also show him how to use a condom correctly. You know, condoms give you dual protection – against pregnancy and against STIs and HIV – but you must use them every single time and correctly. Do you know how to use one?

STEP TWO: EXPLORATION: Counselor explores client’s knowledge of condoms and provides information on dual protection

CLIENT: Not really.

SERVICE PROVIDER: Well, let me show you using this model that represents a penis.

STEP FOUR: SKILLS-BUILDING FOR ACTION: Counselor demonstrates correct condom use on a penis model, describing the steps, and asks the client to repeat the demonstration to assure she understands

[EXPLAIN TO AUDIENCE THAT THE PROVIDER WOULD THEN DO A CONDOM DEMONSTRATION AND ASK THE CLIENT TO REPEAT IT HERSELF TO MAKE SURE SHE UNDERSTANDS]
SERVICE PROVIDER: So, let’s go back to the family planning methods. You said you are interested in the pill, but I want to quickly review the other methods that we have here to make sure that the pill is really the right one for you. But whatever you select, you should know that you could use it with a condom to be extra safe; or you could use condoms alone for dual protection.

EXPLAIN TO THE AUDIENCE THAT THE PROVIDER THEN WILL BRIEFLY DESCRIBE THE OTHER METHODS, ONLY GOING IN DEPTH ON THOSE THE CLIENT EXPRESSES AN INTEREST IN.

SERVICE PROVIDER: So Alicia, we’ve talked about some family planning options that you may be interested in. We also talked about your concerns about HIV/STI risk. What do you think you might like to do to protect yourself from unintended pregnancy and HIV/STIs?

CLIENT: I think I would like the pill.

SERVICE PROVIDER: OK, let’s talk about what you need to know about the pill. First of all, is there anything that you can think of that might get in the way of you taking them every day? EXPLAIN TO THE AUDIENCE THAT THE PROVIDER EXPLAINS HOW TO TAKE THE PILL IN DETAIL AS IN THE PREVIOUS ROLE PLAY SINCE IT IS THE METHOD SHE IS MOST INTERESTED IN, AND MAKE SURE THAT THE CLIENT REPEATS BACK INSTRUCTIONS ON HOW TO USE IT. THE PROVIDER ALSO EXPLORES THE CLIENT’S POTENTIAL OBSTACLES TO TAKING THE PILL CORRECTLY, AND HELPS HER TO THINK OF WAYS TO OVERCOME THESE OBSTACLES.

SERVICE PROVIDER: What about your concerns about HIV/STIs? The pill will protect you from unintended pregnancy, but it will not protect you from HIV/STIs. What are you thinking about in terms of HIV/STI prevention?

CLIENT: Maybe I’ll try some condoms, too. I’d also like to have a talk with my husband about HIV and STIs, if I can...

STEP THREE: DECISION-MAKING: Counselor provides more detailed information on how to use other methods that the client expresses an interest in] 
[STEP FOUR: SKILLS-BUILDING FOR ACTION: Counselor makes sure that the client understands how to use the methods she has selected and helps the client to develop a plan of action for HIV/STI risk reduction and pregnancy prevention]

SERVICE PROVIDER: I will give you a packet of pills. Please come back to see me on October 10th and I will give you more. I am also going to give you some condoms to try, and you can always come here or go to the store to get more. You can use the condoms to practice, or to try out. When you come back in October, we can talk about how your discussion with your husband went, and we can think about the next steps. If you would like to talk with me again sooner, please feel free to come back. Do you understand every thing I have told you?

STEP FOUR: SKILLS-BUILDING FOR ACTION: Counselor provides samples of condoms to the client and instructions on how to obtain more; counselor invites the client
back for a follow-up visit to provide ongoing support with decision-making, negotiation and condom use]

CLIENT: Yes.

SERVICE PROVIDER: Okay, you are ready to go. Do you have any other questions?

CLIENT: No, not right now.

SERVICE PROVIDER: I will see you on the 10th of October. Goodbye.

CLIENT: Goodbye.
PARTICIPANT HANDOUT:
ALICIA VISITS A FAMILY PLANNING CLINIC (CASE STUDY VERSION 2:
DUAL PROTECTION GATHER VERSION)

SERVICE PROVIDER: Alicia?

CLIENT: I am Alicia.

SERVICE PROVIDER: Hello, I am Maria, I am a nurse at this clinic. [smiles] Please sit down and make yourself comfortable. [pause] Why have you come today?

[EXPECT AND ASSESS/ASK: Counselor welcomes the clients warmly, introduces herself, inquires about the reason for the client’s visit]

CLIENT: I am interested in getting a birth control method.

SERVICE PROVIDER: OK, Have you ever used family planning?

[EXPECT/ASK: Counselor explores client’s use of family planning]

CLIENT: Well, we usually just avoid having sex during the middle of my cycle.

SERVICE PROVIDER: OK, what do you know about other family planning methods?

[EXPECT/ASK: Counselor explores client’s knowledge of family planning]

CLIENT: Well, my sister uses the pill, so I guess that would be a good method for me. I have also heard about something about the IUD from a friend.

SERVICE PROVIDER: What do they say about these methods?

[EXPECT/ASK]

CLIENT: My sister likes the pill very much, although she has gained some weight, and I don’t really know much about the IUD.

SERVICE PROVIDER: Well, I would like to explain some more to you about these methods, and also show you the other contraceptive methods that we have so that you can decide which one you prefer. First, I would like to ask you a few questions. Hmmmm . . . I see from your record that you have two children, one that is a baby, and one that is five. Are you breastfeeding?

[EXPECT/ASK: Counselor asks general questions]

CLIENT: No, not any more.

SERVICE PROVIDER: Do you have any plans to have more children?
CLIENT: Well, my husband and I have not discussed this, but I think we want to have one more in a few years, when our youngest is in school. I have two girls and my husband wants to have a boy.

SERVICE PROVIDER: You mentioned that you are interested in the pill?

CLIENT: Yes, I think I would like the pill. I would not mind gaining weight.

SERVICE PROVIDER: What do you know about the pill?

[ASSESS/ASK: Counselor explores client’s knowledge of a family planning method]

CLIENT: I know that it prevents pregnancy and you should take one pill every day.

SERVICE PROVIDER: Yes, that is correct. The pill is very good for protection against pregnancy, but did you know that it does not provide any protection against sexually transmitted infections including HIV? Why don’t you tell me what you know about STIs and HIV?

[ASSESS/ASK: Counselor explores client’s knowledge of HIV/STIs]

CLIENT: Well, I know that AIDS is deadly. I know that people who have a lot of different sex partners and people who use drugs can get it. I know that you can have it for a long time without knowing, and it takes a long time before you actually get sick. As for STIs, well, I have heard of syphilis and some others, but I don’t know much about them.

SERVICE PROVIDER: Good, you already know a lot about AIDS. I just want to clarify a few things. First, AIDS is caused by a virus called HIV. Not only drug users and people with a lot of sex partners can get it. Anyone can get it if they have sex with a person who is infected without using a condom, even if they do not look sick. So, just to review, there are three ways a person can get HIV. The first is through unprotected sex, that is, vaginal sex, oral sex or anal sex. You can also get other STIs though these same types of sex. The second is through blood, which you can get through used injection needles or through contaminated blood transfusions. And third, an infected mother can transmit the virus to her child during pregnancy, birth or breastfeeding.

[EXPLAIN TO THE AUDIENCE THAT THE PROVIDER GIVES SOME MORE INFORMATION ON STIs].

As of now, there is no cure for HIV or AIDS. Our best defense is preventing HIV transmission by minimizing the number of partners we have, and using condoms whenever possible.

[ASSESS/ASK AND TALK/TELL: Counselor explores client’s knowledge of HIV/STIs, gently corrects misinformation and fills in the gaps in knowledge]

As you may know sexually transmitted infections and HIV are a big problem here. Before I tell you more about the family planning methods, I would like to talk with a bit more about your personal life, if I may, to try and get some idea if these are things we should consider when making a decision about a family planning method, or to see if you have other, related concerns. These are questions that I ask of all clients in order to meet their needs for health care. Your
responses are strictly confidential and will not be shared with anyone else. Is that okay?
[GREET: counselor makes the client feel comfortable by assuring confidentiality; explains
that these questions are asked of all clients]

CLIENT: I guess so...

SERVICE PROVIDER: You said that you are married, right? Is your husband the only sexual
partner you have right now?
[ASSESS/ASK: Counselor explores the context of client’s sexual relationships]

CLIENT: Yes, of course.

SERVICE PROVIDER: How long have you been together?
[ASSESS/ASK]

CLIENT: A couple of years.

SERVICE PROVIDER: How is your relationship?
[ASSESS/ASK]

CLIENT: Well, you know how it is.

SERVICE PROVIDER: You told me that you do not have any other partners right now, but have
you had any other partners in the last 5 years or so?
[ASSESS/ASK]

CLIENT: Yes, I was with somebody else before my husband, the father of my first child.

SERVICE PROVIDER: Have you ever thought about whether your husband might have other
partners?
[ASSESS/ASK: Counselor explores the context of client’s sexual relationship by inquiring
whether she thinks that her partner has other sexual partners]

CLIENT: Well….my husband spends too much time away from home….he says he is taking
care of business, but sometimes I wonder…

SERVICE PROVIDER: Is it possible that he has other women when he is away from home?

CLIENT: He probably does…that’s what my sister-in-law told me. I try not to think about it.

SERVICE PROVIDER: Do you think he wears condoms with other women?
[ASSESS/ASK]

CLIENT: No, he hates condoms.
SERVICE PROVIDER: Have you ever thought about whether you are at risk of becoming infected with HIV or another sexually transmitted infection, like gonorrhea or syphilis? [ASSESS/ASK: Counselor assists client to perceive or determine her own risk for HIV/STIs]

CLIENT: No, not really. I wasn’t worried in the past because I trusted my previous boyfriend, but now that you are asking me these questions about my husband, I am starting to become worried that he could pass something to me.

SERVICE PROVIDER: Have you ever talked to him about HIV, STIs, about his relationships with other women or about your sex life in general? [ASSESS/ASK: Counselor explores client’s ability to communicate with her partner]

CLIENT: No, we never talk about those types of things.

SERVICE PROVIDER: Have you or your husband ever had any infections in the past, like discharge or a sore on your genitals? [ASSESS/ASK: Counselor explores client’s and partner’s STI history]

CLIENT: Well, I had an infection once, discharge, and the doctor gave me treatment, but I don’t know what it was.

SERVICE PROVIDER: Well Alicia, you are right to be concerned about STIs, and it is difficult for me to know whether the infection you had was an STI or whether it was another type of infection. But, if you ever have anything like that in the future, an unusual discharge, pain when you have sex, unusual pain in your lower abdomen, irritation, a blister or a sore on your genitals, it is important to come into the clinic to get it checked out. Also, if your husband has any of these symptoms, you should also get checked yourself because some STIs don’t show symptoms for quite a while in women, but they could be doing damage. [EXPLAIN TO THE AUDIENCE THAT THE PROVIDER ALSO GIVES INFORMATION ON VOLUNTARY COUNSELING AND TESTING FOR HIV.]

[TALK/TELL: Counselor provides information about STI transmission and treatment and HIV testing, relating the information to the client’s and partner’s situation]

CLIENT: I will.

SERVICE PROVIDER: How would you feel if your husband used condoms? [ASSESS/ASK]

CLIENT: I think I would feel better, but how could I get him to use them? We don’t talk about those types of things.

SERVICE PROVIDER: Well, the most important thing is to talk with him. How do you think he would react if you brought up the subject?
[HELP: Counselor helps client to anticipate potential outcomes of decisions by exploring how she thinks her partner will react]

CLIENT: I am worried that he might accuse me of having an affair or something.

SERVICE PROVIDER: Well, you might want to try to find a time and place when there are no other distractions, and try to bring up the subject in a way that doesn’t make him angry, maybe when he is in a good mood. You can read this booklet with him as a way to bring up the subject. Do you think that would work?

[HELP: Counselor discusses client’s fears and concerns about communicating and negotiating with partner and offers ideas for improving communication]

CLIENT: Well, I can try.

SERVICE PROVIDER: Well, if that really doesn’t work, maybe you can figure out a way to try to encourage him to use condoms with other partners, if he does have them. You might try a subtle approach like leaving condoms in his drawer or his pocket.

[HELP: Counselor discusses risk reduction strategies such as leaving condoms where male partners will find them]

CLIENT: [Laughs] Well, I’ll think about that, too.

SERVICE PROVIDER: Well, if it goes well, you can also show him how to use a condom correctly. You know, condoms give you dual protection – against pregnancy and against STIs and HIV – but you must use them every single time and correctly. Do you know how to use one?

[ASSESS/ASK AND EXPLAIN: Counselor explores client’s knowledge of condoms and provides information on dual protection]

CLIENT: Not really.

SERVICE PROVIDER: Well, let me show you using this model that represents a penis.

[EXPLAIN: Counselor demonstrates correct condom use on a penis model, describing the steps, and asks the client to repeat the demonstration to assure she understands]

SERVICE PROVIDER: So, let’s go back to the family planning methods. You said you are interested in the pill, but I want to quickly review the other methods that we have here to make sure that the pill is really the right one for you. But whatever you select, you should know that you could use it with a condom to be extra safe; or you could use condoms alone for dual protection.
SERVICE PROVIDER: So Alicia, we’ve talked about some family planning options that you may be interested in. We also talked about your concerns about HIV/STI risk. What do you think you might like to do to protect yourself from unintended pregnancy and HIV/STIs?

CLIENT: I think I would like the pill.

SERVICE PROVIDER: OK, let’s talk about what you need to know about the pill. First of all, is there anything that you can think of that might get in the way of you taking them every day?

SERVICE PROVIDER: What about your concerns about HIV/STIs? The pill will protect you from unintended pregnancy, but it will not protect you from HIV/STIs. What are you thinking about in terms of HIV/STI prevention?

CLIENT: Maybe I’ll try some condoms, too. I’d also like to have a talk with my husband about HIV and STIs, if I can...

SERVICE PROVIDER: I will give you a packet of pills. Please come back to see me on October 10th and I will give you more. I am also going to give you some condoms to try, and you can always come here or go to the store to get more. You can use the condoms to practice, or to try out. When you come back in October, we can talk about how your discussion with your husband went, and we can think about the next steps. If you would like to talk with me again sooner, please feel free to come back. Do you understand every thing I have told you?

CLIENT: Yes.

SERVICE PROVIDER: Okay, you are ready to go. Do you have any other questions?
CLIENT: No, not right now.

SERVICE PROVIDER: I will see you on the 10th of October. Goodbye.

CLIENT: Goodbye.
PARTICIPANT HANDOUT: SUGGESTED QUESTIONS FOR EXPLORING A CLIENT’S SEXUAL AND REPRODUCTIVE HEALTH NEEDS, RISKS AND SOCIAL CONTEXT

Here are some suggested questions to explore with clients:

- How many sexual partners have you had in the past 3 years?
- When you have sex, what kind of sex do you have?
- Do you have vaginal sex with your partner? Anal sex? Oral sex?
- Do you ever use condoms?
- If yes, what has been your experience with them?
- How do you feel about your current or most recent relationship?
- How do you feel about the sex you have with this person? Are you satisfied?
- Who decides when and how you will have sex?
- Aside from your primary partner, do you have other sexual partners?
- Do you think your partner may have other sexual partners?
- Have you ever talked to your partner about family planning?
- Have you ever used any kind of contraception (family planning methods) in your sexual relationships? If so, which methods? How frequently have you used these methods? How did you feel about them? How did your partner feel about them?
- Specifically, have you ever used condoms?
- If not, would you be interested in using condoms in your current or future relationships?
- Have you ever talked to your partner about sexually transmitted infections or HIV/AIDS?
- Have you ever talked to your partner about your sexual life in general?
- To your knowledge, have you or any of your past or current partners ever had a sexually transmitted infection?
- Have you ever had sores in the genital area or discharge from your (penis/vagina)?
- Do you experience any pain during or after sex with your partner?
- Do you experience any burning or other discomfort when you urinate?
- Do you feel any itching, burning, or other discomfort at any other times?
- Can you tell me about your spouse, sexual partner, or partners? Whom do you live with?
- What questions do you have about what might happen to your body during sex?
- Did you agree or consent to all of your past sexual experiences?
- Do you have any questions or concerns about your sexual relationship that you would like to discuss?
- How do you feel about your current sexual relationship?
- How likely do you think it is that you may be at risk of HIV/STIs? How likely do you think it is that your partner could be at risk of HIV/STIs?
- How would you feel about (a/another) pregnancy at this time? How do you think that your partner would feel?
- How would you feel about (a/another) pregnancy in the future? How do you think that your partner would feel?
- Do you inject drugs? Does your sexual partner inject drugs?
PARTICIPANT HANDOUT: SEXUALITY AND HIV/STI RISK: BROACHING THE SUBJECT WITH CLIENTS*

When counseling clients on sexual and reproductive health issues, we often need to ask very personal, sensitive questions. This can be challenging for the client, who may not be used to discussing such personal things with someone other than a family member, or with anyone at all. It can be challenging for providers or counselors as well, since they must be able to obtain the information in order to address clients’ risk of unintended pregnancy and infection with HIV/STIs, as well as clients’ concerns about sexuality.

GETTING STARTED
It is best to start with general, open-ended questions to get the conversation rolling. Asking open-ended questions about a client’s reasons for coming to the clinic, her general health, and more, will help pave the way for the more sensitive questions you will ask.

Later you can probe with more pointed questions to obtain specific information. You should introduce the discussion in your own way, depending on the setting, the client, and the type of service the client is seeking or the complaint the client presents with.

Examples
Assure the client that the questions are routine and that everyone is asked the same questions. For example:

“I am going to ask some very personal questions now. We ask these questions of everyone, because we believe that sexual lives are an important aspect of health.”

Assure the client that the questions will have direct bearing on the client’s health care and the decisions made during the visit:

“It is important for me to ask you these types of questions so that I can help you to make health decisions that are right for you.”

Be sure that the client feels comfortable:

“If there are any particular questions you do not feel comfortable answering, feel free to let me know.”

Introduce the questions within the context of HIV/STI risk:

“As you may know, HIV and other sexually transmitted infections occur a lot in this area. I’d like to talk with you more about your situation so that we can determine if you might be at risk. We discuss this with all of our clients so that we can make sure everyone gets the information and family planning method that best meets their needs.”


WORKING DRAFT
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GENERAL QUESTIONS
You may start with some very general questions to get the conversation going, such as these:
• Do you have any questions or concerns that you would like to discuss about your sexual relationships?
• Can you tell me about your spouse, sexual partner, or partners? Whom do you live with?
• Tell me about your sexual experiences.
• What questions do you have about what might happen to your body during sex?
• Are you happy with your sex life? Why or why not? Do you talk with your partner about it?
• Tell me about your first sexual experiences (particularly for younger clients).

GETTING SPECIFIC
More pointed questions can often be integrated into a discussion of medical history, demographics, or risk factors pertinent to the service being provided. If the information does not emerge through general discussion, ask probing questions on HIV/STI risk, family planning, prenatal or postpartum concerns, or other relevant issues.

Probing: asking specific questions
This list of issues should not be used as a checklist; it is merely a guide to help you remember the information points that are key to elicit. Questions about a client’s sexual life, practices, risks and social context should be worked into a two-way conversation about the client’s individual situation.

HIV/STI risk
During the exploratory discussion, try to elicit information about key issues in order to assist the client to perceive and determine his or her risk for STIs, including:
• Number (and gender) of sexual partners currently and in the past
• Knowledge of partner’s sexual practices and other partners
• Condom use
• History of STIs/infections
• Sexual practices and behaviors

Prenatal concerns
During discussion with prenatal clients, try to elicit information about potential concerns related to sexuality, including:
• Lack of interest in sex
• Increased time for arousal
• Insufficient lubrication
• Pain during or after intercourse
• Vaginismus (difficulty allowing the vagina to relax enough to allow anything to enter)
• Diminished orgasm or loss of orgasm
• Fear of hurting the fetus
• Postcoital bleeding
• Cultural taboos around sexual intercourse during pregnancy that may lead her partner to seek out other partners during that time (increasing risk to the client when sexual activity resumes)
Postpartum concerns
During discussion with postpartum clients, try to elicit information about potential concerns related to sexuality, including:
• Problems associated with resumption of sexual activity since birth of the child
• Pain (vaginal or pelvic)
• Insufficient lubrication (breastfeeding women)
• Lack of desire
• Diminished (or absence of) orgasm

Family planning concerns
In addition to information about contraceptive history and needs, reproductive intentions, and potential contraindications, explore factors associated with sexuality that may impact upon contraceptive choice and continuation, including:
• Fear of becoming pregnant or fear of disease
• Concerns about negative impact of the method (e.g., condoms, other barrier methods) on sexual pleasure
• Diminished sexual response due to use of hormonal methods
• HIV/STI risk (see above)

Other issues for any client
• Past surgery or diseases relevant to sexual functioning
• Sexual concerns with onset of menopause
• Sexual dysfunction in client or partner
• Pain during sex
• Lack of desire, orgasm, or sexual satisfaction
• Insufficient lubrication
• Age at first intercourse
• Experience of recent or past sexual coercion or violence
• Impact of drug or alcohol use on sexual activity and risks
• Partner’s use of, support of, and communication about contraceptive use or disease prevention

Some sample questions about a variety of topics
• When did you first become sexually active?
• Can you tell me about how many sexual partners you have had to date?
• Were these partners male or female?
• Did you agree or consent to all of your past sexual experiences?
• Have you ever used any kind of contraception (family planning methods) in your sexual relationships? If so, which methods? How frequently have you used these methods? How did you feel about them? How did your partner feel about them?
• Specifically, have you ever used condoms?
• If not, would you be interested in using condoms in your current or future relationships?
• To your knowledge, have you or any of your past or current partners ever had a sexually transmitted infection?
• What kinds of sexual practices have you and your past or current partners done together? How do you have sex? (Note: A client will often respond, “We have sex.” It’s important to be specific about what “sex” means to the client. If she says, “intercourse,” find out if that is vaginal or anal, as well as whether she has performed or received oral sex). Be sure to use a gender-neutral term when referring to a client’s sexual partner until the client has revealed the sex of his or her partner.
• Do you have any other partners besides your primary partner? Do you think that your partner may have other partners?
• Do you experience any pain during or after sex with your partner?
• Do you experience any burning or other discomfort when you urinate?
• Do you feel any itching, burning, or other discomfort at any other times? Do you or have ever you had an unusual discharge from your (penis/vagina)?
• Do you have any questions or concerns about your sexual relationship that you would like to discuss?
• How do you feel about your current sexual relationship?
• How likely do you think it is that you may be at risk of HIV/STIs? How likely do you think it is that your partner could be at risk of HIV/STIs?
• How would you feel about (a/another) pregnancy at this time? How do you think that your partner would feel?
Perhaps the most significant issue in helping clients to be willing to take some steps toward reducing their risk is clients’ perceptions of whether they are actually at risk. In many cases, people underestimate their risk and perceive themselves to be at less risk than they actually are. People have many reasons for underestimating their own risk, some of these might include:

**Stereotyped beliefs about who is at risk.** Many people still mistakenly believe that truck drivers, migrant workers, homosexuals, sex workers, and intravenous drug users are the only people who are at risk for HIV. They think that just because they are in a heterosexual relationship, they are safe from risk – or that because they are in a marriage or monogamous relationship they can trust that their partner won’t have any other partners. For many women, in particular, messages about reducing risk by “being faithful” may give a false sense of safety since they are most often at risk due to the behavior of their partners rather than that of their own.

**The illusion of invulnerability.** Some people may have a personal belief that they are immune to risk regardless of their behaviors. People generally tend to underestimate their own personal risk in comparison to the risk faced by others who are engaging in the very same behaviors. An example would be an adolescent girl who thinks she won’t get pregnant even if she has sex without using a method of family planning: “It won’t happen to me.” Adolescents often think of themselves as invulnerable to many things as part of their emotional development.

**Fatalism.** Fatalism is a belief that circumstances are beyond one’s control. Nothing a person does will change what is going to happen anyway. An example of this would be a person who believes that spiritual forces determine how many children you will have, therefore it is not necessary to use family planning.

**Bigger or more urgent problems.** A person may have other concerns that need immediate attention and that put the threat of HIV/STIs or unintended pregnancy into the background. People who live in communities where hunger, violence or poverty is widespread, for example, are more likely to prioritize other issues, such as feeding and protecting their children from harm.

**Misconceptions about risk.** Mistaken beliefs may interfere with a person’s understanding of what is actually risky. For example, a person might not have a clear understanding of how HIV is spread (i.e., they might believe that HIV can be transmitted through contact with toilet seats, or through the sharing of eating utensils, etc). Another example would be a young woman who mistakenly believes that the first time that she has sex that she cannot get pregnant.

**Traditional gender roles and societal expectations.** Different societal expectations and social norms often influence clients’ behavior. For example, a woman might suspect that her husband

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is having extramarital relationships, but it may not be acceptable within her social or cultural role to bring this to his attention. Therefore, it is easier for her to not acknowledge or to minimize the potential risk, when there is little or nothing she feels she can do about it.
The Stages of Behavior Change Model suggests that individuals go through a series of steps or “stages” before a particular behavior change becomes ongoing or permanent. The role of the health provider is to intervene in specific ways during each of the stages in an effort to help the client progress from stage to stage. It is considered to be a “forgiving” model, meaning that clients are expected to “recycle” back through the model (“relapse”) at least once, if not several times, through the process.

**Stages of Behavior Change**

**Stage #1: Precontemplation**

During this first stage, people are unaware that a given problem exists; or on some level, they know that there is a problem, but deny that the potential consequences are as serious as they appear. They may also understand that the behavior is risky, but believe for one reason or another that they are not susceptible to the risk. Finally, they may be aware of the risk, but have still decided not to change their behaviors. Behavior change does not happen during this stage. Further, clients are usually not open to hearing suggestions about resolving the problem during this stage because they do not believe it is relevant to them.

**Example:** An 18-year-old woman is in a relationship where she is faithful to her boyfriend, but she is aware that he has sex with other women. Because they have been together for a year, he has decided that they no longer need to use condoms, and that she should use oral contraceptives (“the pill”) for pregnancy prevention. He uses condoms with some of his other partners, but not with all. When asked if she is aware of her risk for HIV/STIs, the woman says that it is not an issue because she has only ever been with her current boyfriend.

**Stage #2: Contemplation**

At this point, a person has realized that a problem exists, and that it does apply to her or him. However, the person has no intention of making any changes to her or his behavior. This may be because the realization of the risk is fairly recent, and therefore can feel overwhelming. Therefore, the client may realize that change is necessary, but may not feel that she or he is capable of making the necessary changes. This stage can last for an indeterminate period of time before the client either moves to the next stage or abandons the idea of changing the behavior altogether.

**Example:** Using the example above, the woman realizes that even though she has only one partner, the fact that he has had other sex partners and not used condoms with them means that

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he could have been exposed to HIV or another STI. Therefore, she could have been exposed to it as well. However, she is not sure what to do about it.

Stage #3: Preparation

In the preparation stage, the individual is motivated to make a behavior change. The client is still not making significant changes to her or his behavior, although she or he may be taking some initial steps that will lead to more significant changes.

Example: At this time, the woman might talk with her counselor about her options in this situation. For example, some of these options might include: going back to using condoms consistently with her boyfriend for dual protection (prevention against pregnancy and infection with HIV/STI); asking her boyfriend to use condoms consistently with his other sex partners as well; asking that they remain monogamous in their relationship. If testing for HIV and/or other STIs is accessible to her and available in her community, she might consider testing for herself and discussing testing with her boyfriend.

Stage #4: Action

During this stage, an individual is actively changing her or his behavior, consistently and for an ongoing period of time. Since the behavior change is recent, it is common for people to relapse during this time to a previous stage.

Example: Because the client is the woman and not her boyfriend, the action must focus on what she can and cannot do acting on her own. Her actions might include: having the conversation with her boyfriend about using condoms again and getting tested; using condoms; abstaining from intercourse and other high-risk behaviors until the test results are revealed; and/or possibly ending her relationship with her boyfriend if he is not willing to take the necessary steps to protecting their health.

It is important to recognize the difficulties of behavior change in this instance in which the partner’s behavior, and not the client’s behavior, places the client at risk. The action, therefore, must focus on what behavior changes are within the power and control of the client.

Stage #5: Maintenance

If an individual reaches the maintenance stage, she or he has continued to live according to the behavior change for an ongoing period of time. It does not mean that relapse is not possible; however, the longer a person remains in the maintenance stage, the less likely it is for a relapse to occur.

Example: If the woman remains in maintenance, she will continue to use condoms correctly and consistently every time she has intercourse. Alternatively, if she were to leave her boyfriend and begin a new relationship, she would negotiate condom use with her new partner.
Some professionals discuss this model in the context of six stages, referring to the sixth stage as relapse, or when a person returns to the previous behavior that she or he was hoping to change. However, since relapse can occur at any point during the attempted behavior change, we discuss it here as a separate issue rather than as part of the formal model.
## PARTICIPANT HANDOUT: STAGES AND SUGGESTED INTERVENTIONS

<table>
<thead>
<tr>
<th>STAGE OF CHANGE</th>
<th>STAGE-SPECIFIC INTERVENTIONS</th>
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<tbody>
<tr>
<td><strong>PRE-CONTEMPLATION</strong></td>
<td>• Try to help clients see that they are at risk, or susceptible, to the negative consequences of the behavior.</td>
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<tr>
<td>• Client has no understanding of risk.</td>
<td>• Personalize the risk by providing information that is specific to the client. For example, if a 32-year-old man has multiple partners, does not use condoms, and does not see his risks for HIV and other STIs, you could provide statistics, brochures, and any other materials that are specific to men his age, who live in his community.</td>
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<tr>
<td>• Client has no intention of changing behavior.</td>
<td>• Don’t push a client to see what may be obvious to you. However, there is not much more you can do at this stage than provide as much information you can. It will be up to the client to see his own risk.</td>
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<tr>
<td><strong>CONTEMPLATION</strong></td>
<td>• Continue the interventions from the previous stage.</td>
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<td>• Client sees there is some risk.</td>
<td>• Continue to try to show the client that he is susceptible. Help him to understand that change is possible. This can be through:</td>
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<tr>
<td>• Client still not ready to make change.</td>
<td>• If feasible, having him speak with other people, again with a similar background to his, who have contracted HIV or other STIs, or experienced an unintended pregnancy by engaging in similar behaviors.</td>
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<tr>
<td>• Relapse to pre-contemplation is possible.</td>
<td>• Having the client evaluate the pros and cons, or the potential consequences (both positive and negative) of changing the behavior through awareness-building and values clarification exercises. For example, talking through their feelings with a trusted friend, if possible.</td>
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<td></td>
<td>• Positively reinforce any steps the client makes and encourage him to continue talking with a trusted friend.</td>
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<td></td>
<td>• Don’t pressure the client. The counselor’s role is to support clients to come to their own conclusions and decisions. When counselors see that the client realizes that there is a problem and even considers changing, they are often tempted to jump in and push the client to change. However, this can be overwhelming to the client, and cause him to give up altogether.</td>
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</table>
### PREPARATION
- Client understands risk.
- Client decides that he or she wants to make a change.
- Client takes steps that will help him to make a change.
- Client may experiment by making smaller changes leading to larger or more longer-lasting ones.
- Relapse is possible.

### ACTION
- Client has changed the behavior, and is continuing to do so for at least a short period of time.
- Relapse is possible.

### MAINTENANCE
- Change in behavior is ongoing, and has become a part of client’s life.
- Relapse is possible.

- Continue the interventions from the previous stage.
- Whenever feasible, continue to provide “real life” opportunities for him to speak with people who will help him to see his susceptibility and the potential benefits of changing his behavior.
- Help clients develop a plan that identifies and limits obstacles to changing behavior, that will not make a given situation worse, and that they believe will work.
- Have clients continue to reflect on their values and commitment to implementing their plans.
- Positively reinforce any steps the client makes. Do not be critical towards any relapses, but encourage the client to continue to do what he’s been able to do before.
- Again, don’t pressure the client! The more a counselor pushes, the more likely it is that the client will become overwhelmed and relapse to a previous stage.

- Provide as much positive reinforcement to the client as possible. This can include interventions from previous stages, such as continuing to provide up-to-date information about the risky behavior, referring to support groups, and/or facilitating ongoing contact with the individuals who helped the client to see his or her susceptibility at an earlier stage.
- Praise progress, and help clients identify and develop support for keeping up the new behavior.
- Be patient when relapse occurs. Remind clients of their previous successes, and that change is possible. Encourage them to continue trying.

- Provide as much positive reinforcement to the client as possible.
- Help clients recognize the “triggers” (contributing factors) to relapse and practice skills to help them resist a return to former behaviors.
- If appropriate and feasible, suggest follow-up visits to check client’s progress and provide any additional support the client may need.
- Be patient when relapse occurs. Remind clients of their previous successes, and that change is possible. Encourage them to continue trying.
PARTICIPANT HANDOUT:
THE STAGES OF CHANGE “STICK FIGURE” DIAGRAM*

* Adapted from UCSF AIDS Health Project 1998, Building Quality HIV Prevention and Counseling Skills: The Basic 1 Training
PARTICIPANT HANDOUT:
SAMPLE SCENARIOS: CLIENT CASE STUDIES

**Example 1:** Ana, an 18-year old, comes to your clinic with her friend, Maria, who has a visit with a provider. Ana wants to be supportive of Maria, who has come in for a follow-up visit to make sure that an STI has been properly treated. Maria was infected by her boyfriend, Juan, who Ana knows has many sex partners. When Maria goes in to see the provider, a counselor asks Ana if she would like to talk about her own sexual and reproductive health needs. For example, would she like to discuss her own risks for STIs, including HIV, and unintended pregnancy? Ana declines – after all, she has been with her fiancé, Javier, for over a year, he is the only person she’s ever had sex with, and they plan to get married. She uses the pill for contraception. He did tell her that he had chlamydia before, but he was treated and it’s never come back. Since Javier said he got it from a toilet seat, Ana doesn’t feel she is at risk herself.

What stage is Ana in? How do you know?

How would you intervene? What do you think would definitely not work?

**Example 2:** Patrick, a 27-year-old man, has been married for 4 years and has 2 children. He and his wife use oral contraceptives (OCs) as their method of contraception. His wife does not know that Patrick sometimes has sex with men. He knows that he could become infected with HIV and other STIs if he does not use condoms with his other partners. He is terrified that if he got infected he might infect his wife, not only making her ill, but also perhaps exposing his secret. He has been meeting in secret with another man, Justin, a 38-year-old man, for 6 months. While they used condoms together for the first few months of their relationship, Justin said he didn’t like how they felt. Patrick has heard that your clinic offers HIV testing. He would like to be tested for HIV and some other STIs. He also would like Justin to be tested, and to start using condoms again, but he’s not sure of how to ask. He’s afraid of scaring Justin away.

What stage is Patrick in? How do you know?

How would you intervene? What do you think would definitely not work?

**Example 3:** Marguerite, a 42-year-old married woman, comes to see you because she has had pain urinating. While she is there, she tells you that she has noticed some whitish fluid at the tip of her husband’s penis, and that it gives off a strong odor. When she asked her husband about it, he said it was something that happens to all men, and there is nothing to worry about. When you ask whether she or her husband have had sexual relationships with other people, she becomes indignant, and reminds you that they are married.

What stage is Marguerite in? How do you know?

How would you intervene? What do you think would definitely not work?
Example 4: Marcel is a 19-year-old man comes to the clinic with Marie, his girlfriend of 8 months. Marcel says that in the past he did not know very much about HIV or STI prevention, so he did not see any reason to use condoms. After being cured of gonorrhea, which he contracted from a previous girlfriend, Marcel realized that it was important to use condoms and has ever since. Marie says that she was a virgin before they met. Now that he and Marie have been monogamous for so long (and have used condoms their entire relationship), he does not think he needs to continue using condoms and would like to use another method for pregnancy prevention.

What stage is Marcel in? How do you know?

How would you intervene? What do you think would definitely not work?

Example 5: Angela is a 24-year old woman who comes to the clinic to talk about family planning because she has 3 young children and cannot afford to have another one right now. During your conversation, Angela reveals that she is currently working in commercial sex to support her children. Her clients do not like to use condoms and she is afraid that she will lose business if she insists that they do. She has tested positive for syphilis and has had other STIs in the past.

What stage is Angela in? How do you know?

How would you intervene? What do you think would definitely not work?

Example 6: Edna is a 32-year old woman who is married and has 5 children. She and her husband agree that they don’t want another child right now so she has come to talk to you about family planning. During your conversation, Edna confides in you that she knows her husband has other partners, including a family with another woman. When you talk to her about condoms she says that her husband would never use them and that he often hits her and the children when he gets upset. Both Edna and her husband have had STIs in the past.

What stage is Edna in? How do you know?

How would you intervene? What do you think would definitely not work?
Example 7: Rose is a 21-year old woman who has been doing commercial sex work for the past three years to support herself and her 2 children. She uses condoms consistently with all her clients. She does not use condoms with her steady boyfriend, Philip, who she knows has other sexual partners and does not use condoms. In your conversation, she tells you that she feels that not using condoms with Philip sets him apart from her clients and makes sex more “intimate.” She has come to the clinic to find out more about HIV testing, including where she can get a test. Some of her friends who are also commercial sex workers are talking about getting tested and she thinks this might be a good idea given that it is hard to tell which clients are “clean.”

What stage is Rose in? How do you know?

How would you intervene? What do you think would definitely not work?

Example 8: Joseph is a 23-year old migrant worker who is married and has 3 children. Joseph is away from home for several months at a time due to his work schedule. When he is away from home, he often has sex with other women. He uses condoms with all his partners, except his wife, Ruth. He has come to the clinic because he is afraid that Ruth will become pregnant again soon and wants to delay having a fourth child until his income is more regular. He would like to talk to a provider about family planning.

What stage is Joseph in? How do you know?

How would you intervene? What do you think would definitely not work?
PARTICIPANT HANDOUT:
STEPS TO CREATING A PLAN FOR REDUCING RISK

Determine how much the client knows about how HIV and other STIs are and are not transmitted and/or how to prevent unintended pregnancy.

Correct any misinformation (gently and with respect for the client).

Find out about the client’s sexual and reproductive needs, risks and social context. This includes:
- Current and past partners
- Any information about the partners of current or past partners
- Sexual practices (vaginal, oral, anal, etc.)
- Use of family planning methods including condoms
- History of STIs (for self and partners)
- Pregnancy history
- HIV status (if known)
- Home life situation (assess for partner violence, etc.)

Discuss past and present condom use, including client’s attitude (and client’s perception of partner’s attitudes) about using condoms.

Determine client’s willingness and ability to take steps to reduce his or her risk (as he or she perceives and defines that risk, i.e., the client may feel at risk for a variety of concerns including, HIV, other STIs, pregnancy, sexual violence, etc.).

**BE SPECIFIC!** If clients say that they are going to do something, find out when they are going to do, under what circumstances, and what their next steps will be in each situation. Asking a client, “What will you do next?” is important in developing a plan to reduce risk.

Ask about social supports. Who is in the client’s life that can help with the client reduce risk? Who might end up creating obstacles? How will the client deal with a lack of support, or individuals that interfere with the client’s efforts to reduce risk?

Help the client to explore the feasibility of decisions and to anticipate the consequences of decisions. How will partners react? Does a client fear loss of economic support or violence? How will the plan affect relationships with partners? Can clients communicate directly about the plan with partners? Will indirect communication be more effective at first?, etc.

Go over the plan with the client, repeating it and assuring the client’s agreement and comprehension. If the client is literate, there are writing materials available, and appropriate systems of confidentiality exist in your facility, consider writing the plan down and providing a copy for the client, if he or she feels that it is appropriate. Do not insist that the client take a
copy, however, since it may not be safe or appropriate for him or her to bring it home. In most settings, however, written plans are neither appropriate nor feasible.

Ask client to return, if possible, to re-evaluate the plan (if possible). Once the plan has been established, it is possible that when the client attempts to make the changes, the plan won’t work as well in reality. Check in with the client to see what worked, what did not, and what should be done differently in the future. Suggesting a follow-up visit is important, even if it is unclear whether the client will be able to return.
PARTICIPANT HANDOUT
ROLE PLAY SCENARIOS: CREATING A PLAN FOR REDUCING RISK WITH A CLIENT

Note: If necessary, alter these role plays or develop new ones that are more relevant to the context in which the participants work.

Client 1: You are a 45-year-old woman. You and your husband have been married for nearly 30 years. You were a virgin when you got married, and have never had any other sex partners. You and your husband occasionally have sex, however, he frequently goes to sex workers outside of the town in which you live. You are aware of this, and appreciate that he is showing you respect by going outside of the area so that rumors will not be started about you and him. You do not know if he uses condoms. You and your husband have seven children. You have heard that there is an operation that a woman can have to prevent more pregnancies. You assume that this operation will prevent STIs, including HIV, as well.

Client 2: You are a 22-year-old woman from a village far away from where you currently live, who has been married for a year. It was an arranged marriage, and your husband is 20 years older than you are. The relationship is emotionally abusive, and he has even threatened to hit you if you did not do what he says. You have sex with him because it is your duty, but you have not yet become pregnant. You know he has sex with other women, and suspect that he may have sex with other men as well. One time you asked him about it, and he flew into a rage, breaking things in your home, stormed out, and returned home drunk several hours later.

Client 3: You are a 30-year-old woman who has been married for 10 years. You and your husband have known each other since childhood and care about each other deeply. You were home alone one day recently and a stranger forcibly entered your house and raped you. The man did not use a condom, and disappeared, never seen in town again. You have not told anyone (including your husband), about the rape because you are ashamed of what happened and fear that your husband will leave you if he finds out. You are hearing more and more people talking about HIV, and are concerned about whether you could have been exposed to it. You have heard that using condoms can prevent it. However, you and your husband have never used condoms, and you believe that if you ask him to start using condoms, your husband will become suspicious, thinking that you are having sex with another man.

Client 4: You are 24-year old married man who travels frequently for work. When you are on the road you find it tempting to pay for sex with sex workers. You never use condoms because you don’t like how they feel. Instead, you believe that you can tell who is “clean” and who is not. One time you developed an uncomfortable discharge from your penis and went to the pharmacist who gave you some medicine to take and also to bring to your wife. You took the medicine and felt better and gave it to your wife telling her that you caught an infection from using a dirty bathroom on the road and that she may have caught it from you. She took the medicine without asking any questions. Lately she seems to have become suspicious, asking you about what you “do” on the road. You are a little worried about getting an infection again.
**PARTICIPANT HANDOUT:**  
**SAMPLE FORM FOR PLANNING FOR REDUCING RISK**

*Note:* This is a sample structure for organizing the information needed for helping a client develop a plan to reduce risk. In most settings, it will not be feasible to fill out a form such as the one below. Rather, this form is provided for the purpose of practicing plan-making as a part of this exercise.

<table>
<thead>
<tr>
<th>Client background information</th>
<th>Knowledge of HIV and STI transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social supports</td>
<td>Knowledge of family planning</td>
</tr>
<tr>
<td>Client sexual history and current sexual behaviors (including condom use)</td>
<td>Perceived risk for HIV/STIs</td>
</tr>
<tr>
<td>Family planning history</td>
<td>Perceived risk for unintended pregnancy</td>
</tr>
<tr>
<td></td>
<td>Perceived risk for other concerns (e.g., violence)</td>
</tr>
</tbody>
</table>

*In order to reduce my risk for HIV/STIs and/or pregnancy and/or violence [select concern(s) for client], I will:*

_____________________________________________________________________________

*This plan will work if:*

_____________________________________________________________________________

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

_____________________________________________________________________________

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

_____________________________________________________________________________
**PARTICIPANT HANDOUT: SAMPLE PLAN FOR REDUCING RISK**

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

<table>
<thead>
<tr>
<th>Client background information</th>
<th>Knowledge of HIV and STI transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yashira, age 21, married; arranged marriage. 3-month old baby. Came to clinic for IUD. Husband age 40, not working right now (seasonal laborer); drinks alcohol. Occasionally yells when he is drunk, but has never hit her or their baby.</td>
<td>Believes that HIV is transmitted by promiscuous people, homosexuals, sex workers and foreigners. Has heard that HIV/STIs can be spread by mosquito bites and sharing cups and utensils. Believes people with HIV look very thin and have a certain color to their eyes. People with STIs get very serious sores and their genitals dry up and they can no longer have or make babies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social supports</th>
<th>Knowledge of family planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has 1 sister who lives in next village, a 2-hour walk away; parents dead. Has a close friend who lives nearby.</td>
<td>Has heard of OCs, IUD, condoms, sterilization. Sister uses IUD and likes it.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client sexual history and current sexual behaviors (including condom use)</th>
<th>Perceived risk for HIV/STIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Played kissing games as an adolescent; was a virgin when married. Has never used condoms. Husband was married before; suspects that he probably has other partners. Has no idea about his past or current condom use.</td>
<td>Believes it is possible that her husband is at risk, but assumes that he will be able to tell which women do and do not have HIV and choose carefully.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family planning history</th>
<th>Perceived risk for unintended pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has never used a method of family planning. Not sure if her husband has.</td>
<td>Stopped having sex with husband right after birth of baby. Now that the baby is 3-months old, her husband wants to have sex again. Afraid of a pregnancy too soon. Wants IUD.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perceived risk for other concerns (e.g., violence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worried about husband’s drinking and potential for violence, especially when he is out of work.</td>
</tr>
</tbody>
</table>
In order to reduce my risk for HIV/STIs, pregnancy and violence, I will:

• Talk with my husband about using family planning and tell him that I would like to use the IUD to prevent pregnancy for a couple of years until our baby is older.
• Talk with my husband to find out whether he is using condoms with other partners. If he does not, I will ask him to consider using them with his other partners or with me (for dual protection) to protect us both from infection.
• Will talk to my husband about spending the night at a friend’s house the nights he goes out drinking because “I feel scared to be alone” (this will protect me if he comes home drunk and violent).
• I will bring home literature from the clinic on family planning and HIV/STI prevention so that he can read the material and understand why I am concerned.

This plan will work if:

• My husband is willing to talk with me about family planning and HIV/STI prevention.
• My husband allows me to spend the night at a friend’s house when he goes out.
• My husband agrees to use a method of family planning to prevent pregnancy (including condoms).
• My husband agrees to use condoms to prevent HIV/STIs with me or his other partners.

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

• Provider
• Husband
• Myself
• Friend

I will come back for a follow-up visit to see how well the plan is going on: 30 days from today
PARTICIPANT HANDOUT:
HELPING CLIENTS COMMUNICATE WITH THEIR PARTNERS*

Assess clients’ willingness and ability to talk with partners, giving particular attention to their values or feelings about sex, the nature of their relationship with their partners, issues of economic survival or personal safety, and cultural norms related to what is appropriate for women to do or say.

- Explore what clients mean if they say they “trust” their partners, or “I’m in a monogamous relationship.”
- Listen for assumptions, i.e., “My partner would never agree to do that.”
- Ask what it might be like to discuss the difficult subject with their partner.
- Validate concerns they may have about discussing these issues.
- Listen for issues of personal safety or survival, and acknowledge that they are real concerns.
- Offer options, but do not tell the client what to do.
- Help to develop skills by weighing potential costs and benefits, by role playing with the client, etc. (For example, offer to role play with the client with you playing the part of the partner so the client can practice strategies for bringing up the difficult subject.)
- Ask what clients think their partners will say or do when they bring the topic up.
- Ask clients how exactly they intend to bring the topic up, including the time, place and words they will use.
- Ask clients, “How are you feeling right now, talking with me about talking with your partner?” Doing so will provide a sense of the clients’ willingness, resourcefulness, comfort level and likelihood of actually having the discussion.

If appropriate, confront contradictions: “You say you love your partner, and vice versa. Can you tell me what it’s like to be in a relationship in which you don’t talk about subjects that are important to you such as (INSERT TOPICS OF CONCERN TO THE CLIENT):
- …protecting yourselves from HIV/STIs?”
- …preventing unintended pregnancy?”
- …how many children you want to have?”
- …painful sex or sexual problems?”
- …infections that you think you may have?”
- …other sexual partners?”
- etc.

Point out past successes: “You say you’ve been in this relationship for a long time. What difficult subjects have you successfully been able to bring up and talk about in the past?” (Look for examples such as religious practices, relations with in-laws, raising children, finances, etc.)

Remember that behavior change happens in small, incremental steps: Counseling sessions will have been equally successful if clients leave questioning previously held assumptions as if they leave with the determination and skills to have a conversation with their partner.
**PARTICIPANT HANDOUT: OBSERVATION OF ROLE PLAY (Option 1)**

**Instructions:** Please use this form to note your reactions to the role plays you just observed:

How did the counselors communicate? Were they:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>If YES, how did you know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathetic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respectful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrete/Mindful of confidentiality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attentive/Listening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unbiased/Nonjudgmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unhurried</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What did the counselors do to make the client feel comfortable?

How did the counselors determine the client’s knowledge of sexuality and explore the client’s sexual history? What could the counselors have done differently?

How did the counselors assess the client’s risk for HIV/STIs and/or unintended pregnancy? How did the counselors help the clients articulate any other concerns about their sexuality or reproductive health? What could the counselors have done differently?

Did the counselor miss any important cues or pieces of information from the clients?

What specific information did the counselors provide? What other information should have been provided?

How did the counselor assist the client to develop a plan of action for reducing risk?

Did the counselor make referrals to services that could support the client in implementing his or her plans? (For example, a referral to VCT services).

What could the counselors have done to save time? What information could have been left out?
PARTICIPANT HANDOUT: OBSERVATION OF ROLE PLAY (Option 2)

Instructions: Please use this form to make notes about how the “counselor” in the role play that you just observed worked with the “client” and accomplished the following steps.

STEP ONE: Introductions

- Welcoming the client
- Introductions
- Assuring confidentiality
- Help the client to relax and feel comfortable

STEP TWO: Exploration

- Exploring clients’ needs, risks, sexual lives, social context and circumstances
- Providing information about HIV/STI transmission and prevention and/or pregnancy prevention and dual protection
- Assisting clients to perceive or determine their own risk for HIV/STI transmission and/or unintended pregnancy

STEP THREE: Decision-making

- Discuss dual protection, HIV/STI prevention and/or pregnancy prevention options
- Assist clients to make realistic decisions
- Help clients to anticipate the potential outcomes (positive or negative) of their decisions
- Discuss risk reduction options
STEP FOUR: Skills-building for action

- Develop partner communication and negotiation skills

- Develop condom use skills

- Develop other family planning method use skills

- Develop a plan for carrying out decisions

- Make referrals to community resources to support clients in realizing decisions (e.g., referrals to VCT services)
PARTICIPANT HANDOUT: SUGGESTED ROLE PLAY TOPICS

1. An HIV-positive client who is pregnant comes to the clinic for counseling and the provider pushes her to schedule an abortion.

2. An HIV-positive client comes to the clinic for a family planning method and the provider insists that she consider only long-term or permanent methods such as sterilization.

3. A group of nurses and clinic assistants are gossiping about an HIV-positive client in front of other clients.

4. An angry husband comes to the clinic and demands to know the results of his wife’s HIV anti-body test.

5. A woman who is HIV-positive and has recently developed symptoms of AIDS ends up in the clinic’s waiting room with her 3 children after her husband and in-laws threw her out of the house and she has no where else to go.

6. When an HIV-positive woman who is known to be a sex worker leaves the clinic after a family planning visit, other women in the waiting room loudly complain that they do not appreciate being treated in an environment where “sick” and “dirty” women are seen. They don’t want the same doctors, nurses or equipment touching them.
PARTICIPANT HANDOUT: COUNSELING HIV-POSITIVE WOMEN*

Always support the client’s family planning decisions, even if you personally disagree with her choices. Adopt a neutral attitude and give the following information:

• Her life expectancy
• Pregnancy does not appear to accelerate HIV progression.
• An HIV-infected mother can transmit the virus to her child. In some countries, rates of MTCT exceed 40 percent.
• If it is available in your setting, some preventive treatment can reduce HIV transmission risks during childbirth.
• What it would mean to take care of a child with HIV, including the course of the child’s infection and the likelihood of early death.
• The kind of family or social support she can expect to receive. Are there family members who would care for orphaned children, etc.?
• Teach correct condom use and skills for negotiating condom use with her partner.
• If she does not wish to become pregnant, discuss dual protection, including dual method use (condoms and another method of contraception).
• Explain which family planning methods protect against HIV transmission and which do not.

* Adapted from: FHI Network, Volume 20, Number 4, 2001, p. 11.
**PARTICIPANT HANDOUT: DEALING WITH STRESS WHEN WORKING IN A CLINIC**

<table>
<thead>
<tr>
<th>When FAMILY AND FRIENDS say to you:</th>
<th>You can respond with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Why do you work at that place with <em>those people</em>?”</td>
<td></td>
</tr>
<tr>
<td>2. “You mean you actually promote family planning and talk about HIV and sex?”</td>
<td></td>
</tr>
<tr>
<td>3. “I thought you could get a better job than this.”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When CLIENTS say to you:</th>
<th>You can respond with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “I waited so long to come in to see you because I was scared.”</td>
<td></td>
</tr>
<tr>
<td>2. “I don’t want to talk to you about this. I want to see someone else.”</td>
<td></td>
</tr>
<tr>
<td>3. “How long have you been doing this work? Are you sure you know what you’re doing?”</td>
<td></td>
</tr>
</tbody>
</table>

*Adapted from Pathfinder International, Session 10, “Special Stresses and Counseling”*
### When CO-WORKERS or a SUPERVISOR say to you:

1. “That’s not my job.”
2. “I’m held up. Can you take my clients for me?” (repeatedly)
3. “I’m so stressed out – I’m the busiest person in the clinic!”
4. “We are not going to be able to give anyone more money this year. However, we need to ask for additional time from all staff.”

### You can respond with:

### When the COMMUNITY says to you:

1. “Your work encourages promiscuity.”
2. “It should be illegal to give out condoms to kids.”
3. “There is no AIDS in our community.”
4. “You’re really just trying to cut down on the population in our community by promoting family planning.”

### You can respond with:
<table>
<thead>
<tr>
<th>When YOU realize for YOURSELF:</th>
<th>You can respond with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “We are out of pills and condoms!”</td>
<td></td>
</tr>
<tr>
<td>2. “There are 50 women in the waiting room and I have only 2 hours in which to see them.”</td>
<td></td>
</tr>
<tr>
<td>3. “I’ve said this five times in a row and the client still isn’t understanding me.”</td>
<td></td>
</tr>
<tr>
<td>4. “This clinic is filthy.”</td>
<td></td>
</tr>
<tr>
<td>5. “I know this client – I had higher expectations of her.”</td>
<td></td>
</tr>
</tbody>
</table>
### PARTICIPANT HANDOUT: HEALTHCARE PROVIDER SHIELD *

<table>
<thead>
<tr>
<th>What I do well…</th>
<th>What are my weaknesses or challenges…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Three people in my life who support me…</th>
<th>What I intend to do to combat stress…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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* Developed by Wayne Pawlowski, Planned Parenthood Federation of America.

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**WORKING DRAFT**

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PARTICIPANT HANDOUT: PROVIDER SELF-ASSESSMENT TOOL

Instructions for the provider: Fill out this form at the end of a counseling session with any client. (It is a good idea to assess counseling sessions that you thought went particularly well or those that you thought could have been improved, in order to assess a range of sessions.) You can use this form as frequently as you want (for example, for one client each day). The information that you record is primarily for your own learning process, but you may wish to share it with others, including your supervisor.

Date __________________________

1. What was the reason this client came to the clinic today?

2. Was the visit (circle one):
   ____Too long  ____An appropriate length  ____Too short

3. If the session was too long or too short, what role, if any, did you play in this?

4. How did you ensure proper confidentiality for the client? (If you did not, explain why).

5. What aspects of the client’s sexual life did you explore?

6. How did you address dual protection? (If you did not address it, explain why).

7. What did the client intend to do about his or her sexual and reproductive health concerns after your session?

8. Did the client agree to come in for a follow-up session?

9. How did you feel working with this client? Why?

10. Do you think he or she could tell that you felt this way? If so, do you think that helped or hindered the session? Why?

11. What are three things you feel you did effectively with this client?

12. What are three things you wish you had done differently with this client?

13. What steps are you going to take in an effort to ensure that you will make these changes with future clients?