Part I

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

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

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

Integrated sexual and reproductive health counseling is defined as:

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

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

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

Rationale: Why Integrated SRH Counseling?

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

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

You Are the Client

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

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

If you were this woman:
• Would you return to this clinic for STI counseling? Why or why not?

• What opportunities did the provider miss to help meet your needs?

• How could the provider have met your needs better?

Note to participants: Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.
Session 2  
Defining Sexual and Reproductive Health and Integrated SRH Counseling

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

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

**Essential Ideas—Session 2**

- Sexual health and reproductive health are overlapping and intertwined concepts. Thus, the combined term sexual and reproductive health has emerged to include all aspects of health related to sexuality and reproduction.

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

- Integrated SRH counseling is a critical component of integrated SRH services, in that it helps clients make best use of the range of services available. However, integrated SRH counseling can be offered in any service-delivery setting, with clients being referred for services not provided on-site. In addition, integrated SRH counseling can be an important component of outreach services, as a means of helping individuals identify their needs both for clinical care and for nonclinical strategies for changing their behavior.

- A common understanding of these terms helps providers better address clients’ SRH needs and better communicate with colleagues about SRH.

- Although service providers may be limited in their work to the services that are offered at their service site, they should be aware of other services available in the community, so they can help clients access services not provided at that site.
Definitions

Sex

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

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

Sexuality

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

Sexuality:

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

Gender

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

Sexual Orientation

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

Reproductive Health

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

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


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

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

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

The IWHC describes the basic elements of sexual health as:

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


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

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

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

- Physical, mental, and social well-being related to sexuality and reproduction
- Freedom to enjoy sexual relations without fear of pregnancy, disease, or abuse of power, sexual coercion, or violence
- Equal balance of power in sexual relations
- Respect for bodily integrity and the right to control one’s own body
Session 2

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

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

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

Components of SRH Care
According to the Programme of Action adopted at the ICPD in 1994 (Paragraphs 7.2, 7.3, and 7.6), the following are components of SRH care:
- Family planning information, counseling, and services
- Prevention and treatment of STIs and reproductive tract infections (RTIs)
- Diagnosis and treatment of HIV and AIDS
- Antenatal, postpartum, and delivery care
- Health care for infants
- Management of abortion-related complications
- Prevention and treatment of infertility
- Information, education, and counseling on human sexuality, SRH, and parenthood
- Diagnosis and treatment of cancers of the reproductive system
Integrated SRH Counseling

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

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

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

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

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

- The goal of integrated SRH services is to provide comprehensive health care services on-site and to promote linkages between these services. Integrated SRH counseling is a critical component of integrated SRH services that helps clients make best use of the range of services available.

- However, integrated SRH counseling can be offered in any service-delivery setting. Thus, a provider can discuss the full range of SRH issues about which the client may be concerned, regardless of the types of SRH services actually provided at that site. Meeting the client’s needs may require referring him or her to services off-site or may require problem-solving to determine what the client can do about a situation for which services simply do not exist locally.

- Integrated SRH counseling can be provided anywhere and at any time. It does not even need to be directly linked with a clinic setting, because many prevention strategies (e.g., for preventing transmission of HIV or STIs) involve behavior change rather than clinical care. Thus, integrated SRH counseling can be a vital part of outreach services, as a means of helping individuals identify their needs both for clinical care and for nonclinical strategies for changing their behavior.
Session 3
Why Address Sexuality?

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

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

Essential Ideas—Session 3

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

Key Discussion Points

1. Why is it important to address sexuality as a part of integrated SRH counseling?
   • Pregnancy and STIs are both outcomes of sexual activity.
   • Reproductive health programs will have a limited impact if they do not consider the context in which people make decisions about their sexual lives and reproduction. Sexuality and sexual practices can have implications for a client's decisions about contraceptive
Session 3

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

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

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

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

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

- They can learn more about sexuality, to increase their comfort in talking about it.
- They can talk with other providers about their experiences in speaking with clients about sexuality.
• They can explain to the client the reason for discussing sexuality issues, by focusing on the importance of sexuality to the client’s health and assuring the client that they are not asking out of their own curiosity.

• They can use language (i.e., terminology) that is comfortable for them and understandable to the client.

• If the provider is of the opposite sex of the client, they can ask another staff person of the same sex to be present during the discussion.

• Focus groups or interviews with community members or clients can be conducted to better inform providers about the sexuality concerns and service needs of the community.
Session 4
The Problem Tree—
Roots and Consequences of SRH Problems

By the end of this session, you should be able to:
• Identify the causes and consequences of at least three SRH problems
• Describe the provider’s role in addressing the causes and consequences of SRH problems

Essential Ideas—Session 4

• The root causes of SRH problems are very complex, with as many social factors as medical ones, if not more.

• The consequences of SRH problems affect far more people than the clients seeking services—they affect their children, other partners, and sometimes the community. These consequences are also both social and medical.

• Multiple or multifaceted interventions are needed to address both the social and medical causes of these problems.

• Providers may think that they can only offer medical solutions, since their work is limited to the health care setting. However, through counseling, providers can educate clients about their rights and options and help empower clients to make changes in their lives. Providers can also use their role as health care professionals to reach out to communities and leaders, to educate them about the root causes of these problems and about the limitations and potential consequences of relying only on medical interventions.

Note: The content of this session is adapted from IIED, 2000.
Sample SRH Problem Tree: Maternal Health Care

**Consequences:**

- Disruption of families as a result of the death or illness of mothers
- Limited contact with antenatal and postpartum services, leading to lower use of postpartum family planning
- High maternal and infant mortality
- High maternal morbidity

**Problem:**

High-risk home deliveries are common.

**Root causes:**

- Low levels of women's empowerment
- Inaccurate beliefs and misinformation about delivery and complications
- Lack of access to health care
- Poverty
- Poor-quality services at the facility
- Lack of information about where and when to go
- Lack of awareness and ignorance
Session 5
Supporting Clients’
Informed and Voluntary Decision Making

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

Essential Ideas—Session 5

• People’s entitlement to make informed and voluntary decisions about their sexual and reproductive health is supported by several human rights that are recognized by the international community.

• Reproductive rights are recognized by international conventions signed by most countries of the world and include the right to decide on the number, spacing, and timing of children; the right to have the information and means to do so; the right to attain high standards of sexual and reproductive health; and the right to make these decisions without discrimination, coercion, or violence.

• Including women’s “right to exercise control over their own sexuality” in our understanding of sexual and reproductive rights is an important breakthrough, since the right to decide about reproduction and the right “to attain the highest standard of sexual and reproductive health” have little meaning if women cannot decide if, when, and with whom they will have sex.

• Sexual and reproductive rights are only effective when people feel entitled to these rights and empowered to exercise them. Yet, everyday constraints—e.g., power imbalances between social groups, or between men and women—can pose barriers to the exercise of these rights.

(continued)
**Essential Ideas—Session 5 (continued)**

- Individuals and couples can make key decisions that significantly affect their health status in every area of SRH. The ability and means to make informed decisions in each of these areas is a fundamental expression of one’s sexual and reproductive rights.

- At the same time, rights related to access to information and services—e.g., the right to information for unmarried people, the right of access to SRH services for adolescents, or the right to postabortion care without being forced to use a method of contraception—must exist for individuals to be able to make and act on their informed decisions.

- There are five basic elements necessary for informed and voluntary decision making:
  1. Service options are available.
  2. The decision-making process is voluntary.
  3. People have appropriate information.
  4. Good client-provider interaction, including counseling, is ensured.
  5. The social and rights context supports autonomous decision making.

- Each of these basic elements is influenced by factors that operate at three different levels: the level of the individual in the community context; governmental, legal, and SRH programming policies; and factors within the service-delivery setting itself.

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

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

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

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

This term originally was associated with family planning, wherein an individual freely chooses whether to use a contraceptive method and which one, based on his or her awareness of and
understanding of accurate information about the methods. Although informed choice could apply to any SRH service, some providers have difficulty understanding “informed choice” in non-family planning services, because there may be only one treatment option (e.g., only one medication for syphilis, and thus no “choice”) or the individual’s medical condition may require the provider to make emergency decisions for a client (e.g., in postabortion or emergency obstetric care).

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

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

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

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


Decision making about SRH is complex and individualized and is often influenced by an interplay of factors related to individual circumstances—the social and rights contexts in which an individual lives; laws and policies affecting information and services; and practices in service delivery. Strategies to support clients’ rights to make informed and voluntary decisions about SRH need to consider all five basic elements and the factors influencing those elements at the community or individual level, the policy level, and the service-delivery level.
Session 5

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

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

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

Human Rights Supporting Informed and Voluntary Decision Making for Reproductive Health

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

2. Why did you choose these three?

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

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

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

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Session 6
Client Profiles for Sexual and Reproductive Health Decision Making

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

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

**Essential Ideas—Session 6**

• Clients have a wide range of needs and issues that they must deal with to get help for their SRH problems. Each person has a unique combination of background, socioeconomic and gender status, needs, concerns, and information. It is important to consider all of this when helping clients to make SRH-related decisions.

• There are few cases in which a client’s situation affects only himself or herself; someone else is almost always involved in the problem or is affected by whatever decision, if any, the client makes.

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

If you were this man:

- What would be your current SRH needs?

- What decisions would you have to make? Who else would be involved in the decision making?

- What information would you need to make your decisions? Where could you get that information?

- Would you be comfortable seeking services for these SRH needs?

- How would you feel about your situation? What concerns or worries would you have?

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

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

**Essential Ideas—Session 7**

- The rights of the client are a subset of reproductive and sexual rights. They describe the essential aspects of service delivery to ensure quality of care, once a person has chosen to seek health care services.

- There are many people in the clinic setting who play a role in supporting clients’ rights—or in undermining them. It is important to consider the impact of all people with whom the client comes into contact in the clinic setting and determine how to make the best use of these “human resources.”

- **Client-provider interaction** refers to interpersonal communications (either verbal or nonverbal) between health care staff and the people who seek health care services. In this definition, “provider” includes everyone in the health care setting with whom the client interacts. This recognizes the importance of nonmedical staff to clients’ impressions of and messages that they associate with the health care setting.

- A client’s first impressions of a health care facility are usually made through interactions with frontline staff. The client’s sense of trust and confidence that
he or she has made the right decision to seek SRH services can be reinforced or completely undermined by frontline staff.

- *Counseling* is a special type of client-provider interaction. It is two-way communication between a health care worker and a client, for the purpose of confirming or facilitating a decision by the client, or helping the client address problems or concerns.

- Counseling is the main safeguard for the client’s right to informed choice. In addition, counseling can support each of the other clients’ rights.

- Although clinical providers are usually responsible for the final stages of counseling, frontline staff can perform many preliminary steps, such as giving information about the client’s options and gathering basic information about the client’s condition.

- Utilizing frontline staff to cover initial phases of counseling, such as information-giving and information-gathering, allows providers to spend more time with the client on individual considerations and the actual decision-making process.

### The Rights of Clients

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

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

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

**Safety of services:** Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service-delivery guidelines, the existence of quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.
**Privacy and confidentiality:** Clients have a right to privacy and confidentiality during delivery of services—for example, during counseling and physical examinations and in staff’s handling of clients’ medical records and other personal information.

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

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


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**Client-Provider Interaction**

**Definition**

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

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

**Purposes**

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

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

*Note:* Adapted from: INTRAH/PRIME, 1997.
Session 7

**Principles**
Key principles in client-provider interaction include the following:

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

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

**Counseling**

**Definition and Tasks**

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

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

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

**Essentials**

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

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

**Principles**

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

- Create an atmosphere of privacy, respect, and trust
- Engage in two-way communication with the client
• Ensure confidentiality
• Remain nonjudgmental toward values, behaviors, and decisions that differ from your own
• Show empathy for the client’s needs
• Demonstrate comfort in addressing sexual and gender issues
• Remain patient during the interaction with the client and express interest
• Provide reliable and factual information
• Support the client’s sexual and reproductive rights
Potential client (teenage female) enters gate of clinic.

**Negative interaction**

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

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

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

**Positive interaction**

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

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

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

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

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

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

Essential Ideas—Session 8: Option A

• The REDI framework (which stands for Rapport-building, Exploration, Decision-making, and Implementing the decision) is suitable for integrated SRH counseling in the following ways: It emphasizes the client’s responsibility for making a decision and for carrying it out; it provides guidelines for considering the client’s sexual relationships and social context; and it addresses the challenges that a client may face in carrying out this decision and offers skills-development to help clients meet these challenges.

• The most important thing to remember about counseling models is that the client is more important than the framework. Frameworks can be helpful to providers in giving you a structure for talking with the client, so that you do not miss important steps. Too often, though, the provider may focus more on following the steps than on responding to what the client is saying. The bottom line in counseling is to first figure out what the client needs and then how to help him or her meet those needs.

• Whatever framework is used for counseling, it is important to personalize counseling sessions by exploring each client’s individual situation, as opposed to talking generally about family planning methods or HIV and STI transmission and prevention. By personalizing the discussion and applying it to the client’s specific situation, you can help clients to perceive their own risks, rather than think of unintended pregnancy or AIDS as “things that happen to other people.”

(continued)
Essential Ideas—Session 8A (continued)

- During client-centered counseling, avoid overloading clients with unnecessary information. To do this, you should first examine the client’s situation and then tailor the session to meet his or her needs.

- Understanding and exploring the social context of decisions is critical to helping clients determine their risk and make realistic decisions about pregnancy, HIV and STI prevention, and safe motherhood. This context includes a client’s power to make decisions about reproduction and sexuality and the people and factors that influence a person’s decisions, such as partners, family members, or friends. This also includes anticipating the outcomes of decisions, such as whether a decision (like suggesting condom use with a husband) could lead to violence.

- With integrated SRH counseling, voluntary and informed decision making is based on the client’s understanding and perceiving his or her own situation and risks, and having enough knowledge about options and their consequences to make decisions. It also involves considering the social and personal context for decision making by the client, supporting clients’ rights to access information and services and helping the client to figure out a way to make his or her own decisions within that context.

- REDI provides a useful framework, but this does not mean that it must be followed exactly or in sequential order during a counseling session. REDI is merely a suggested guide of steps and topics to cover while the provider and client engage in an interactive two-way discussion of the client’s needs and risks.

### REDI (Short Version)

#### Phase 1: Rapport-building
- Welcome the client
- Make introductions
- Introduce the subject of sexuality
- Assure confidentiality

#### Phase 2: Exploration
- Explore the client’s needs, risks, sexual life, social context, and circumstances
- Assess the client’s knowledge and give information, as needed
- Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk

#### Phase 3: Decision making
- Identify what decisions the client needs to make in this session
- Identify the client’s options for each decision
- Weigh the benefits, disadvantages, and consequences of each option
- Assist the client to make his or her own realistic decisions

#### Phase 4: Implementing the decision
- Make a concrete, specific plan for carrying out the decision
- Identify skills that the client will need to carry out the decision
- Practice skills, as needed, with the provider’s help
- Make a plan for follow-up

*Note: Adapted from: EngenderHealth, 2002; Pyakuryal, Bhatta, & Frey, no date; and Gordon & Gordon, 1992.*
REDI: Rapport-Building, Exploration, Decision Making, and Implementing the Decision

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

**Phase 1: Rapport-Building**

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

**Phase 2: Exploration**

1. Explore the client’s needs, risks, sexual life, social context, and circumstances
   - Assess what the client understands about his or her SRH condition or situation, what worries or concerns he or she might have, and what he or she specifically hopes to accomplish through the visit
   - Explore the context of the client’s sexual relationships:
     - What sexual relationships is he or she in, what is the nature of the relationships (including any violence or abuse), and how does he or she feel about it?
     - How does he or she communicate with partners about sexuality, family planning, and HIV and STIs?
     - What does he or she know about his or her partners’ sexual behavior outside of the relationship?
   - Explore the client’s pregnancy history and knowledge of and use of family planning methods, including condoms
   - Explore the client’s HIV and STI history, present symptoms, and knowledge of partners’ HIV and STI history
Session 8A

- Explore other factors about the client’s circumstances that may limit his or her power or control over decision making, such as financial dependence on partners, tensions within an extended family, and fear of violence, among others.

2. Assess the client’s knowledge and give information, as needed
   - Assess the client’s knowledge of pregnancy-related care (if appropriate), postabortion care (if appropriate), family planning, HIV, and STIs
   - Correct misinformation and fill in gaps, as needed

3. Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk
   - Ask the client if he or she feels at risk for unintended pregnancy or for HIV and STI transmission, and explore why or why not
   - Ask the client if he or she thinks that his or her partners may be at risk for unintended pregnancy or HIV and STI transmission, and explore the reasons
   - Explain HIV and STI transmission and pregnancy risks (as necessary), relating them to the individual sexual practices of the client and his or her partners
   - Help the client to recognize and acknowledge his or her risks for HIV and STI transmission or unintended pregnancy

Phase 3: Decision Making

1. Identify what decisions the client needs to make in this session
   - Help the client to prioritize the decisions, to determine which are the most important to address today
   - Explain the importance of the client’s making his or her own decisions

2. Identify the client’s options for each decision
   - Many providers and clients feel that in most areas of SRH, the client’s decision-making options are limited. An important role of the provider is to lay out the various decisions that a client could make, to explore the consequences of each. This empowers the client to make his or her own choice, which is a key element of supporting the client’s sexual and reproductive rights.

3. Weigh the benefits, disadvantages, and consequences of each option
   - Make sure the discussion centers on options that meet the clients’ individual needs, taking into account their preferences and concerns
   - Provide more detailed information, as necessary, on the options that the client is considering
   - Consider who else would be affected by each decision
   - Explore with the client how he or she thinks that partners or family members may react to the course of action (i.e., suggesting condom use or discussing sexuality with partners)

4. Assist the client to make his or her own realistic decisions
   - Ask the client what is his or her decision (i.e., what option he or she chooses)
   - Have the client explain in his or her own words why he or she is making this decision
   - Check to see that this decision is the choice of the client, free of pressure from spouse, partner, family members, friends, or service providers
   - Help the client to assess whether his or her decision can actually be carried out, given his or her relationships, family life, and economic situation, among other issues
Phase 4: Implementing the Decision

1. Make a concrete, specific plan for carrying out the decision
   - Be specific. If a client says that he or she is going to do something, find out when, under what circumstances, and what his or her next steps will be in each situation. Asking a client “What will you do next?” is important in developing a plan to reduce risk. For example, if a client says that he will start to use condoms, the provider should ask, “How often?” “Where will you get the condoms?” “How will you pay for them?” “How will you tell your partner that you want to use them?” and “Where will you keep them so you will have them with you when you need them?”
   - Ask about possible consequences of the plan: “How will your partner(s) react?” “Do you fear any negative consequences?” “How will the plan affect relationships with your partners?” “Can you communicate directly about the plan with your partners?” and “Will indirect communication be more effective at first?”
   - Ask about social supports. Who in the client’s life can help the client carry out the plan? Who might create obstacles? How will the client deal with a lack of support or with individuals who interfere with the client’s efforts to reduce risk?
   - Make a “Plan B”—that is, if the plan does not work, then what can the client do?

2. Identify skills that the client will need to carry out the decision (see number 3, below)

3. Practice skills, as needed, with the provider’s help
   - Partner communication and negotiation skills
     - Discuss the client’s fears or concerns about communicating and negotiating with partners about condom use, family planning, maternal health concerns, safer sex, or sexuality, and offer ideas for improving communication and negotiation
     - For a client who feels that it may be difficult to negotiate condom use for HIV and STI prevention, discuss whether it might be easier to introduce condoms for pregnancy prevention
     - Role-play with the client possible communication and negotiation situations
   - Condom-use skills
     - Demonstrate correct condom use on a penis model, describe the steps, and ask the client to repeat the demonstration to be sure that he or she understands
     - Discuss strategies for making condom use more acceptable to partners
     - Provide samples of condoms (if possible) and make sure that the client knows where and how to obtain more
   - Skills in using other family planning methods
     - Make sure that the client understands how to use other family planning methods that he or she has selected by asking the client to repeat back basic information and by encouraging him or her to ask for clarification

4. Make a plan for follow-up
   - Invite the client to return for a follow-up visit to provide ongoing support with decision making, negotiation, and behavior change
   - Explain timing for medical follow-up visit or contraceptive resupply
   - Make referral for services not provided at your facility
Discussion Summary

1. How does this framework ensure that the counseling is client-centered?
   - The framework starts with the client’s situation and takes into account the client’s individual circumstances. Each counseling session can then be tailored to the client’s needs.

2. How much time do providers in your facility generally spend counseling each client? Do you think this framework helps providers to work within this time frame? Do you think providers can save time with this framework? If yes, how? If no, why not?
   - Providers can ultimately save time by learning first about the client’s situation and then limiting the information-giving portion of the session to addressing what the client truly needs to know, rather than providing detailed information on every option.
   - At first, it might take longer for providers to follow the framework because they may need to adjust to the new way of interacting with clients.

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

4. How does this framework ensure a client’s informed and voluntary decision making?
   - The framework focuses on helping clients make their own informed decisions and develop skills to carry out these decisions, rather than on steering the client to a particular decision.
   - The framework helps clients understand and perceive their own risks for unintended pregnancy and HIV or STI transmission and provides them with knowledge about the various options to protect themselves, allowing them to make informed decisions.
Session 8
Counseling Frameworks
Option B: GATHER

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

By the end of this session, you should be able to:
• Incorporate sexuality, HIV and STI prevention, postabortion care, and maternal health care into the GATHER counseling framework
• Explain the importance of applying counseling frameworks to each client’s unique situation
• Explain the importance of addressing the social context for decision making in integrated SRH counseling
• Describe how integrated SRH counseling supports informed and voluntary decision making by clients

Essential Ideas—Session 8: Option B

• The GATHER approach can be an important tool to ensure that providers are client-focused, since it emphasizes learning about the client and having a dialogue together, rather than talking at the client. Ensuring informed choice is a critical element of GATHER.

• Revising GATHER to address HIV and STI prevention, sexuality, maternal health care, postabortion care, and family planning involves thinking about the whole client. Specifically, this involves exploring the following: the client’s circumstances, the nature of his or her sexual relationships, how he or she perceives risks (of pregnancy, HIV and STIs, pregnancy complications, or sexual violence, among others), and how the provider can help the client to protect himself or herself and lead a healthy, satisfying sexual and reproductive life.

• The most important thing to remember about counseling models is that the client is more important than the framework. Frameworks can be helpful to providers in giving you a structure for talking with the client, so that you do not miss important steps. Too often, though, the provider may focus more on following the steps than on responding to what the client is saying. The bottom line in counseling is to figure out first what the client needs and then how to help him or her meet those needs.

(continued)
Essential Ideas—Session 8B (continued)

- Whatever framework is used for counseling, it is important to personalize counseling sessions by exploring each client’s individual situation, as opposed to talking generally about family planning methods or about HIV and STI transmission and prevention. By personalizing the information about pregnancy and HIV and STI risks and applying it to the client’s specific situation, you can help clients to perceive their own risks, rather than think of unintended pregnancy or AIDS as “things that happen to other people.”

- During client-centered counseling, avoid overloading clients with unnecessary information. To do this, you should first examine the client’s situation and then tailor the session to meet his or her needs.

- GATHER provides a useful framework, but this does not mean that it must be followed exactly or in sequential order during a counseling session. GATHER is merely a suggested guide of steps and topics to cover while the provider and client engage in an interactive two-way discussion of the client’s needs and risks.

- Understanding and exploring the social context of decisions is critical to helping clients determine their risk and make realistic decisions about pregnancy, HIV and STI prevention, and safe motherhood. This context includes a client’s power to make decisions about reproduction and sexuality and the people and factors that influence a person’s decisions, including partners, family members, and friends. This also includes anticipating the outcomes of decisions, such as whether a decision (like suggesting condom use with a husband) could lead to violence.

- With integrated SRH counseling, voluntary and informed decision making is based on the client’s understanding and perceiving his or her own situation and risks, and knowing enough about options and their consequences to make decisions. It also involves considering the social and personal context for decision making by the client, supporting clients’ rights to access information and services, and helping the client figure out a way to make his or her own decisions within that context.
The Dual-Protection GATHER Approach

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

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

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

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

H = HELP the client make the decision that is best for him or her, including developing a plan for reducing risk of HIV and STIs or unintended pregnancy. This does not mean making the decision for the client; it means helping the client determine if he or she is at risk for HIV and STIs or unintended pregnancy and helping the client decide what he or she will do to reduce these risks. This may involve helping the client select a family planning method, keeping in mind potential HIV and STI risk and the impact of the method on sexuality. It also may involve working with the client to anticipate partner reaction to introducing condoms or discussing sexuality or STI risk behaviors, including a negative reaction or violence. It may involve weighing the costs and benefits of introducing condoms. If male condom use is not feasible, it may include discussing other strategies (such as using female condoms or having the partner come for counseling).
Session 8B

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

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

Note: Adapted from: EngenderHealth, 2002.