Part II

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

The provider's attitude toward the client is a key factor in effective counseling. Yet many providers are personally challenged by the necessity to discuss SRH needs, beliefs, and behaviors that may differ from their own, or may have difficulties in addressing these issues with particular types of clients (e.g., unmarried women, adolescents, or men). These training sessions set the stage for discussions about providers' attitudes, values, and beliefs and their impact on clients—discussions that will be reinforced throughout the training during group work, discussions, and role plays.
Session 9
Rapport-Building—
Respect, Praise, and Encouragement

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

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

Essential Ideas—Session 9

• The four steps of “rapport-building” are:
  ➢ Welcome the client
  ➢ Make introductions
  ➢ Introduce the subject of sexuality
  ➢ Assure confidentiality

• Aspects of welcoming the client include being friendly, nonjudgmental, and respectful, and showing interest in the client’s situation and needs.

• Different cultures have different customs for showing respect between individuals. It is important for providers to consider how they show respect for their clients. They should also consider the power imbalances that may exist between themselves and clients, due to socioeconomic status or education, and how such imbalances may affect communications between providers and clients.

• Praise and encouragement can be useful in establishing rapport with clients. Genuine praise and encouragement for clients will show respect for their efforts as individuals to try to deal with health problems, no matter how misguided or uninformed their efforts may be.
Praise and Encouragement

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

Praise

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

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

Encouragement

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

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

Note: Adapted from: Tabbutt, 1995.

Praise and Encouragement: Client Situations and Provider Responses

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

Contract of Respect

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

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

• How do you demonstrate respect for clients and their decisions?

• How do you establish rapport with clients?

• How do you assure clients that discussions are confidential?

• How do you maintain a trusting relationship with clients?

• How do you support clients’ right and ability to make decisions?

• How do you respond respectfully to clients whose values or decisions you do not agree with?

Note to participants: Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.
Session 10
Provider Beliefs and Attitudes

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

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

**Essential Ideas—Session 10**

- Our *beliefs* shape our *attitudes*, or the way that we think about and act toward particular people and ideas. However, our beliefs and attitudes are often so ingrained that we may be unaware of them until we are confronted with a situation that challenges them.

- Everyone has a right to his or her own beliefs. However, health care providers have a professional obligation to provide health care and to do so in a respectful and nonjudgmental manner. Being aware of your personal beliefs and how they affect others—both positively and negatively—will help you do just that.

- How we communicate our beliefs and attitudes (both verbally and nonverbally) is an important aspect of our interactions with clients. Every interaction between health care staff and a client, from the moment he or she enters the health care setting until he or she leaves, affects the client by having an impact on his or her:
  - Willingness to trust and to share personal information and concerns
  - Ability to listen and to retain important information
  - Capacity to make decisions that accurately reflect his or her situation, needs, and concerns
  - Commitment to comply with treatment and to develop new health-related behaviors

**Beliefs and Attitudes in Integrated SRH Counseling**

*Beliefs* are important to individuals. They help us to explain how things “work” in the world—what is right and what is wrong. They usually reflect our values, which are influenced by religion, education, culture, and family and personal experiences.
Our beliefs and values shape our attitudes, or the way that we think about and act toward particular people or ideas. Consider the following statements, which reflect a range of opinions about SRH (but not necessarily those of EngenderHealth or your trainers). How these statements make you feel, and what you believe about these topics, can affect the way you provide services to clients. In this way, your attitudes and beliefs may have both positive and negative impacts on clients and on their decision making regarding SRH. However, our beliefs and attitudes often are so ingrained that we may be unaware of them until we are confronted with a situation that challenges them.

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

"AIDS is mostly a problem of prostitutes."

"Homosexuals can change if they really want to."

"Celibacy goes against human nature."

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

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

Every interaction between health care staff and clients—from the time they enter the health care system until they leave—affects clients’ comfort and their satisfaction with the care they received, how well they carry out decisions made during the counseling session, and whether they come back for follow-up or if problems arise. Regardless of your personal beliefs, as a health care provider you have a professional responsibility to offer SRH care in a respectful and nonjudgmental manner. Being aware of your own beliefs can help you identify the potential for being judgmental and alter your behavior, so as to avoid it and the negative effects that this can have on clients.
Session 11
Sexuality

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

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

Essential Ideas—Session 11

Part A: Reflections on How We Learned about Sexuality
• Our own beliefs and attitudes about sexuality and sexual practices may affect how we talk to our clients about sexuality, as well as our comfort in doing so. Perceiving where our own feelings and beliefs came from can help us empathize with the experiences of clients and understand the difficulties we all have in talking about our sexuality.

• Sexual practices and relationships are affected by the way we feel about sex, what we think is proper and improper, and what it means to relate to another person in a sexual way. These types of thoughts and feelings are often filled with emotions, including pleasure and sometimes fear, guilt, shame, or embarrassment. These feelings come from our personal experiences and also from the meanings that our society and culture attach to sex.

• This exercise alone might not help us to feel more comfortable discussing sexuality with our clients, but it can be a helpful step in the process.

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

(continued)
Essential Ideas—Session 11 (continued)

Part C: Sexual and Social Development

• Sexual development is a lifelong process, combining our bodies’ changing needs with the messages that we constantly receive from our social environment about what is “normal” and about how to fulfill our needs for physical and emotional closeness.

• Early influences in a client’s life may result in unhealthy behaviors as an adult. It is important to help the client understand how or why he or she is unhealthy and to find acceptable ways of changing those behaviors. We can also acknowledge the needs of young people for information and reassurance about SRH, as well as the needs of older adults for information, reassurance, and health care services that support their continuing sexual expression and health beyond the reproductive years.
Participant Worksheet

Reflections on How We Learned about Sexuality

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

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

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

• How do your experiences, beliefs, and attitudes concerning sexuality affect the way you talk with clients?

• How do you think clients’ experiences, beliefs, and attitudes concerning sexuality affect their ability to talk with you?

• How do you feel when discussing sexuality or sexual practices with clients?

• How do you think clients feel when discussing these topics with you?

• What can you do to make yourself or your clients more comfortable with discussing sexuality or sexual practices in the clinic setting?

Note to participants: Participant Worksheets are provided in several places throughout this handbook, and may be used in varying ways during and after the training. Mostly, they are meant to help reinforce key concepts of the training, to give you another way of thinking about what is presented and discussed. So feel free to read and answer the questions at any time—now, or even months from now, when you look back on what you learned.
Session 11

Background Materials

Aspects of Sexuality

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

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

Four Aspects of Sexuality

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

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

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

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

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

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

- **Biological sex** is based on our physical status of being either male or female.
- **Gender identity** is how we feel about being male or female. Gender identity starts to form around age 2, when a little boy or girl realizes that he or she is different from people of the opposite sex.
- **Gender roles** are society's expectations of us, based on our biological sex. What behaviors do we expect of men and what behaviors do we expect of women? And when did we learn to expect these behaviors? These expectations are gender roles, and they begin to form very early in life.
- **Sexual orientation** is the final element of sexual identity. Sexual orientation refers to the biological sex to which we are attracted romantically. Our orientation can be heterosexual.
(attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. However, they actually are expressing different gender roles: Their masculine or feminine behavior has nothing to do with their sexual orientation. A homosexual man may be very feminine, very masculine, or neither; the same applies to heterosexual men. Also, a person may engage in same-sex behavior and not consider himself or herself homosexual.

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

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

**Sexual and Social Development**

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

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

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

- **Begins to have sexual responses.** Occurs before birth. A male fetus achieves genital erections in utero; some males are even born with erections. Sexual responses in females are also believed to occur before birth.
- **Explores one’s own genitals (masturbates) for the first time.** Occurs between ages 6 months and 1 year. As soon as babies can touch their genitals, they begin to explore their bodies.
- **Shows an understanding of gender identity.** Occurs by age 2. Children are aware of their biological sex.
- **Shows an understanding of gender roles.** Occurs between ages 3 and 5. Children begin to conform to society’s messages about how males and females should act.
- **Asks questions about where babies come from.** Occurs between ages 3 and 5.
- **Begins to show romantic interest.** Occurs by ages 5 to 12, although this may vary by culture. At this stage, children show the first signs of sexual orientation (sexual preference toward males or females).
- **Shows the first physical signs of puberty (the transition from childhood to maturation).** Occurs by ages 8 to 12. This usually occurs slightly earlier for girls than for boys.
Session 11

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

- **Begins to menstruate (girls).** Occurs between ages 9 and 16. This milestone depends in part on the child’s nutrition and may be delayed where nutrition is severely compromised.

- **Begins to engage in romantic activity.** Occurs by ages 10 to 15. This milestone depends heavily on cultural factors.

- **Has sex for the first time.** This varies greatly by culture, but mid-to-late adolescence is fairly common across cultures. Many societies have cultural taboos against sexual experience outside of a traditional heterosexual marriage; in other cultures, a couple is expected to have sex—or even conceive a first child—before marriage; and in other cultures, same-sex sexual experiences are common. An individual’s first sexual experience may not be consistent with what society condones. For example, in many societies, girls would be disgraced by having premarital or casual sex, whereas young men in the same culture may be expected or encouraged to have sex before marriage. This does not mean that some—or even many—girls in these cultures do not have premarital sex, but it does mean that they may be afraid to disclose any sexual experience they have had to health care workers or to others.

- **Gets married.** Timing varies greatly by culture. In some cultures, girls and boys are married very young; in others, young girls are married to older men. In some parts of the world, common-law unions are the predominant pattern. However, these relationships, like marriage, are a proxy for age at initiation of sexual activity.

- **Begins to bear children.** Many factors determine when and if a person has a first child. First childbirth varies by community and by individual. In some communities, the first child is expected to be born before marriage (as a proof of fertility) or without marriage. In other cultures, first childbirth is expected to occur after marriage, while in others, pregnancy may lead people to marry. In some cultures, couples increasingly are choosing to delay childbirth or to have no children at all, a change made possible by the availability of effective contraception and, in some cases, induced abortion.

- **Experiences menopause/male climacteric.** Menopause occurs in women at around age 50 (it can start in the late 30s or early 40s as well); male climacteric occurs between ages 45 and 65. Menopause occurs when a woman goes through a process of physiological changes characterized by the end of ovulation, menstruation, and the capacity to reproduce. Male climacteric is characterized by a decrease in testosterone production. For both sexes, this midlife process of transition results in changes in a person’s physical structure, hormonal profile, and sexual functioning.

- **Experiences sexuality in later life.** Older adults (those aged 50 to 60 or beyond) can remain sexually active to the end of their life. Though some age-related changes in sexuality take place, the total loss of sexual functioning is not a part of the normal aging process. Biological changes, illnesses, therapies for those illnesses, and psychological and social factors can affect sexuality and sexual functioning.

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

Sexual and Social Development

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

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

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Session 12
Variations in Sexual Behavior

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

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

Essential Ideas—Session 12

• Although reproductive health providers have offered services for many years, rarely do they discuss sexual practices with clients. HIV and AIDS have heightened providers’ awareness of the need to address sexual behaviors more frankly and directly.

• This exercise is meant to help us understand how providers’ biases about sexual behaviors might affect a client’s feelings about discussing such intimate issues.

• We all make value judgments regarding sexual behaviors and the circumstances under which people engage in sexual practices, but to be effective providers we must not impose our own values on clients as we explore their individual needs and situations.

• The term sex is often thought to refer to penile-vaginal intercourse only, but sexual behaviors can be defined much more broadly. If you assume that “sex” means penile-vaginal intercourse, you may miss important information.

• If a provider does not address the issue of sexual practices, clients may receive inadequate or inappropriate information and may engage in behaviors that increase their risk of infection or unintended pregnancy. Assumptions and misunderstandings about clients’ sexual practices can leave them without the information, skills, or methods they need to protect themselves.
Session 13
Building Rapport with Male Clients and with Adolescent Clients

By the end of this session, you should be able to:
• Describe the special needs and concerns of two types of clients—men and adolescents
• Explain the importance of building rapport immediately with male clients and adolescents
• Describe how providers can build rapport with male clients and adolescents

Essential Ideas—Session 13

• In providing integrated SRH counseling, it is important to be able to meet the needs of all individuals. Most providers are accustomed to dealing with only married, female clients, and may feel awkward talking with men or with unmarried adolescents. In addition, cultural barriers may make it even more difficult to discuss sexuality concerns with someone of the opposite sex or with an unmarried youth.

• These communication barriers make men’s and adolescents’ needs for integrated SRH counseling more acute, as they often cannot get information or services that they need to prevent unintended pregnancy or HIV and STIs and may be accessing services only because they already have a serious problem.

• The purpose of this session is to help you to appreciate the needs and special concerns of these clients, to take the first step toward making such clients feel welcome and comfortable.

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

The following are some characteristics of men that have been identified through cross-cultural research on men’s needs and roles. Again, these characteristics do not define all men, but rather provide a framework for considering approaches to communicating with men.
Session 13

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

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

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

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

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

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

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

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

What might work: The provider might say: “I am sure you already know how to put on a condom correctly, but why don’t I just review a few important points about what some men struggle with....”
Men May Be More Comfortable with Thoughts and Actions Than with Emotions

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

Scenario

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

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

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

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

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

Scenario

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

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

What might work: The provider might say: “I see you are looking at our most popular brochure. You know, many men are concerned about erectile dysfunction. There was a man in here the other day who asked me about treatment, and I told him that a lot of men have been having success using....”
### Sample Phrases to Use When Addressing Men, Based on Their Needs and Roles

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

*Adapted from: EngenderHealth, 2003b.*
SRH Services and Counseling for Adolescents

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

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

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

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

SRH services and counseling can help adolescents:

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

When counseling young people, providers have a responsibility to:

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

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