Part V

Assisting Clients in Making Their Own Voluntary and Informed Decisions

Assisting clients in making voluntary and informed decisions sometimes may be a matter of confirming a decision that the client made before he or she even entered the clinic and sometimes may involve helping the client weigh several options to reach his or her decision. While a provider’s objective may be to help individuals make their decision, often the decision-making process is heavily influenced by gender expectations in the client’s social setting or by power imbalances in personal relationships that may limit the client’s decision-making capacity. Counseling can and should address all of these factors.
By the end of this session, you should be able to:

• Define gender and gender roles

• Describe how gender roles can affect communication between SRH clients and providers and between clients and their partners

• Describe how gender roles can have a negative impact on SRH

Essential Ideas—Session 24

• **Gender** is how an individual or society defines “male” or “female.”

• **Gender roles** are socially or culturally defined attitudes, behaviors, expectations, and responsibilities that are considered appropriate for women and men. Gender roles may vary according to culture, class, and ethnicity.

• Gender roles can affect communications about SRH both between clients and their partners and between clients and providers.

• Gender roles may limit women’s ability to gain access to information and services and their ability to make their own decisions about their sexual and reproductive health. In addition, gender roles may limit a woman’s control over when and with whom she has sexual intercourse or whether she is protected against pregnancy or STIs.

• Gender roles can also have a negative impact on men, by making them reluctant to ask questions about sexuality and show that they do not know everything. A man may also be limited in his access to information and services that are considered to be “only for women.” Also, gender roles that put pressure on a man to be sexually experienced can lead to his being exposed to infection and causing unintended pregnancy.

• Exploring your own sense of gender roles, and how you learned them, is useful for helping you become more sensitive to assumptions that you make about clients and to the impact of your own gender on your communications with clients.
Session 25
The Effect of Power Imbalances on SRH Decision Making

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

• Identify four categories of behavior that people use to control their partners in different types of sexual relationships
• Describe how such behaviors can affect the ability of partners to make and carry out decisions regarding SRH
• Explain the concept of social vulnerability to HIV and STIs or to unintended pregnancy

Essential Ideas—Session 25

• When we think of “power” or “power imbalances” in relationships, we may think of physical force. However, physical force, or abuse, is not the only type of controlling behavior that people experience in relationships. Such behavior comes in many forms—emotional or psychological, financial, and sexual—and can be just as damaging as or even more damaging than physical abuse. Many people who are not physically abused do not even realize that they are being abused.

• Consideration of power or power imbalances in relationships usually leads to thoughts of men using their power to control women. This is not always the case. However, in many cultures, “normal” gender relations and a lack of power in sexual decision making prevent women from protecting themselves from HIV or STIs and unintended pregnancy, even if they are aware that their partner’s behavior is putting them at risk. Because of their social and economic dependence on men, women frequently have little power to refuse sex or to insist on the use of barrier methods, such as condoms. This session focuses on such gender-related power imbalances, since they are more common.

• Factors that contribute to “social vulnerability” to HIV or STIs and unintended pregnancy include gender, economic power, youth, stigmatization of some groups in society, and government policies that create barriers to SRH information and services for women and youth.
# Examples of Behaviors Used to Control a Partner

## Physical
- Hitting
- Kicking
- Biting
- Punching
- Choking
- Restraining
- Pushing
- Pulling hair
- Burning
- Cornering a person and not letting him or her enter or leave a room
- Throwing objects at a person
- Cutting
- Not allowing a person to go to the doctor
- Preventing a person from taking medication

## Emotional/psychological
- Criticizing a person constantly, especially in front of other people
- Calling a person names
- Questioning a person’s intelligence
- Accusing a person of being a bad parent, cook, or lover
- Criticizing a person’s appearance
- Threatening to hurt a person or his or her children
- Following a person around town
- Accusing a person of infidelity
- Threatening to destroy a person’s property
- Not allowing a person to sleep at night
- Threatening a person with weapons without using them
- Threatening to leave the relationship
- Sending a person out to run an errand and timing her departure and return

## Financial
- Not allowing a person to own anything in his or her own name
- Not allowing a person to handle money or make decisions about spending
- Stealing money that a person had from his or her family or from working
- Preventing a person from working
- Not allowing a person to attend or to finish school
- Forcing a person to work several jobs

## Sexual
- Rape
- Forcing a person to do something sexual that he or she does not want to do
- Forcing a person to have sex with another person in front of his or her partner
- Forcing a person to have sex for money
- Forcing a person to view pornographic material
- Criticizing a person’s sexual performance

*Adapted from: EngenderHealth, 2002.*
Social Vulnerabilities and HIV and STI Risk

Some factors that affect social vulnerability are:
- Gender
- Economic power
- Youth
- Culture
- Policies (for example, those related to the illegal status of sex work, condom availability, sex education, and laws regarding homosexuality, among others)

Why Are Women More Vulnerable than Men to HIV and STI Infection?

Biologically
- They have a larger mucosal surface in the vagina; microlesions that can occur in the vagina during intercourse may be entry points for the virus; very young women are even more vulnerable in this respect.
- Viral concentration is higher in sperm than in vaginal secretions.
- As with STIs, women are at least four times more vulnerable to infection; the presence of untreated STIs is a risk factor for HIV.
- Coerced sex increases risk of microlesions, due to the lack of vaginal lubrication.

Economically
- Financial or material dependence on men means that women cannot control when, with whom, and under what circumstances they have sex.
- Many women have to exchange sex for material favors, for daily survival. In addition to formal sex work, there is also this type of exchange, which in poor settings may represent many women's only way of providing for themselves and for their children.

Socially and culturally
- Women are not expected to discuss or make decisions about sexuality.
- Women cannot request (or insist on) use of a condom or any form of protection.
- If women refuse sex or request condom use, they often risk abuse, as there is a suspicion of infidelity.
- The many forms of violence against women mean that sex is often coerced, which is itself a risk factor for HIV infection.
- Women are sometimes expected to have relations with or marry older men, who are more sexually experienced and are thus more likely to be infected. In some places, men seek younger and younger partners so as to avoid infection or in the belief that sex with a virgin cures AIDS and other diseases.

Note: This section was adapted from: WHO, 2000.
Why Are Young People More Vulnerable to HIV and STI Infection?

- Younger people, especially children and adolescents, tend to have less power to resist the demands of an older person.
- Younger people may be coerced into sexual behavior with older people through manipulation or threats (e.g., “I will tell your family that you wanted it”).
- Because older people (particularly men) tend to be more sexually experienced, they are more likely to have been exposed to HIV or STIs and therefore are more likely to pass them on to the younger person (e.g., in many countries, older men seek younger women as sex partners, and therefore women become infected with HIV at much younger ages than do men).

What Policies Make People More Vulnerable to HIV and STI Infection?

- If governments make certain practices or behaviors illegal (such as commercial sex work or sex between people of the same sex), this may place people at greater risk if they do not have access to information on how to protect themselves and are afraid to seek health care.
- Government policies that limit women’s access to education, property, money, and other resources may make women more vulnerable to HIV and STI infection because they must depend on men, giving them less power to negotiate safer sex.
- Government policies that restrict sex education (including information on HIV and STI prevention) in public schools keep younger people unaware of their risks and ignorant about how to protect themselves from infection with HIV or STIs and from unintended pregnancy.
Participant Worksheet

Case Studies on Power Imbalances in SRH Decision Making
(Note: A sample answer for each case study is found on pages 115 and 116.)

Case Study 1
Susheela is a 15-year-old secondary school student. Her family is very poor and often does not have enough money to pay for school fees, books, and uniforms. Lately, Ramesh, a 35-year-old small-business owner, has been paying special attention to Susheela. He has offered her rides in his car and taken her out for meals. Ramesh is married and has two young children. Ramesh tells Susheela that if she is his “special friend,” he will give her money to pay for school expenses, so Susheela has sex with Ramesh. Ramesh is the first person that Susheela has had sex with. She has never discussed sexuality or contraception with her family, nor has she been offered sex education in school. Ramesh tells her not to worry about getting pregnant, because he will make sure it does not happen. He also makes fun of condoms, saying that real men would never use them. Susheela never knows in advance when she will see Ramesh. When Ramesh does find Susheela, he picks her up in his car and takes her to a remote area for sex. When the sex is over, Ramesh tells Susheela he will give her some money for school only if she promises not to tell anyone about what they have just done. He also threatens to hurt her if anyone finds out.
• What factors contribute to Susheela’s vulnerability to unintended pregnancy and infection?
• If you were counseling Susheela, what strategies would you recommend to enable her to protect herself against pregnancy and infection?

(continued)

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.
Participant Worksheet

Case Studies on Power Imbalances in SRH Decision Making (continued)

Case Study 2
Rosa is 25 and married to Carlos; they have four children. Rosa married at age 16 and never completed her education. In the past year, there have been strains on their marriage. Carlos maintains strict control over the household money, yet he has not been able to find steady employment as a laborer. When there is work, Carlos seems happy to provide for the family, but when he is out of work, he spends what little money there is on alcohol and, as Rosa suspects, on other women. When Carlos is out of work, he often comes home drunk and demands sex from Rosa. Rosa complies with his demands even when she does not feel like having sex, because she believes that it is her obligation as a wife. She has been to a health clinic to get a method of contraception. Carlos agreed that it would be a good idea for her to use the pill. About six months ago, when she went for a follow-up visit, the clinic doctor noticed an unusual vaginal discharge and diagnosed Rosa with an STI. She took medicine to treat it but did not tell Carlos, for fear of his reaction. She knows that she must have gotten it from Carlos. Rosa has heard that condoms can prevent STIs, but she knows that Carlos would never use one. In fact, if she asked him to, she fears that he might even leave her, as he has threatened to do before. While they have their problems, Rosa loves Carlos. He is a good father, especially when he is working. If he left, she does not know how she and the children would survive.

• What factors contribute to Rosa’s vulnerability to infection?

• If you were counseling Rosa, what strategies would you recommend to enable her to protect herself against infection?
Participant Worksheet

Case Studies on Power Imbalances in SRH Decision Making (continued)

Case Study 3
Zanela is 30 years old, a mother of three children, and a widow from a very poor country. Her husband recently died in a mining accident. She sells vegetables in the market but makes barely enough to feed her children and maintain the household. To supplement her income, she has begun to go out on the road at night to have sex for money with the truck drivers who come through her village. She has some condoms that she got from a clinic once and sometimes she asks the men to use them. Some men do, but others offer her more money for not using a condom. Given her financial situation, she accepts additional money and forgoes condom use. As far as she is concerned, feeding her children right now is her immediate concern, and this priority is much more important than insisting on condom use to prevent the possibility that she could get pregnant or contract HIV or some other STI.

- What factors contribute to Zanela’s vulnerability to unintended pregnancy and infection?
- If you were counseling Zanela, what strategies would you recommend to enable her to protect herself against unintended pregnancy and infection?

(continued)
Case Study 4
Christopher is a 28-year-old man living in a big city. He is married to Virginia, who is 24, and they have three young children. Christopher loves his family and is a good father and a good provider, and he works hard to give his children a better chance for a good education and a better future. As long as he can remember, Christopher has always felt a sexual attraction for other men, but he has had to hide it all of his life because he knows that this is not accepted in his culture. Christopher knows that there are lots of other men like him, and most of them get married and live a second life like he does. Christopher does not have a regular male sexual partner, because he is too afraid that people might find out, so he goes to several places where men meet other men to have casual sex. None of the men use condoms. Christopher, like most people in his community, has heard about HIV and STIs. He knows that the local health center has information about HIV and STIs, but the people there seem to be concerned with women, and he feels that it would look strange if he were to go there. In addition, he fears that the health practitioners would find out about his having sex with other men and would shame him and tell other people in the community. Meanwhile, Christopher continues to have unprotected sex with Virginia, and she does not suspect anything.

- What factors contribute to Christopher’s vulnerability to infection and risk of transmitting the infection to his wife?
- If you were counseling Christopher, what strategies would you recommend to enable him to protect himself (and his partners) against infection and his wife against unintended pregnancy?

(continued)
Participant Worksheet

Case Studies on Power Imbalances in SRH Decision Making (continued)

Sample answer for Case Study 1:
Susheela is at risk for a variety of reasons. Her poverty makes her vulnerable to exchanging sex for money and supplies for school. The age disparity between Susheela and Ramesh makes her vulnerable, because she may have been taught to “show respect” and trust for older people. Her young age places her at risk biologically, because her vaginal tissues are less mature and more likely to tear, making it easier for infection to occur. Her lack of knowledge related to sexuality, contraception, and infection places her at risk, because she is unable to perceive her own risk and unequipped to protect herself. Cultural taboos against discussing issues related to sexuality at home or in school perpetuate myths about STIs that increase her risk. The gender-related factors include Ramesh’s refusal to use condoms because “real men” do not wear them, which stems from societal attitudes about masculinity. Socialization for women to be compliant and submissive about sex and for men to be aggressive and in control about sex affects the dynamic between Susheela and Ramesh. His threat of violence and control of economic resources are also related to gender roles.

Sample answer for Case Study 2:
Many factors place Rosa at risk of infection. Carlos and Rosa are in an unequal relationship, with Carlos controlling the resources, determining the nature and timing of their sexual activity, and threatening to leave if Rosa defies him. Prevailing attitudes about masculinity and femininity perpetuate a situation in which Carlos demands sex from Rosa and she feels that she must comply, even when she does not want to. Other attitudes about gender roles have influenced this situation, such as expectations that men be “good providers,” expectations that men have multiple sex partners, the notion that drinking makes men “manly,” and the idea that it is a wife’s obligation to provide sex whenever her husband wants it.

Given that Rosa has already experienced one STI, she is at risk of reinfection or infection with another STI, especially because Carlos was not treated. The fact that there are positive elements in their relationship further complicates the situation, because Rosa is even more willing to place herself in risky situations for the “good of the relationship.” However, this also shows that Rosa may be able to talk with Carlos about the STI, if she can choose a good time. Despite all of the factors against her, Rosa has had the insight and means to visit a family planning clinic and is aware that condoms could protect her. She would greatly benefit from counseling to help her develop a risk-reduction plan and to build skills to follow it through.

Sample answer for Case Study 3:
The primary risk for Zanela is her poverty and her status as a single mother struggling to provide for her children. Because she is from a poor country, the government has not prioritized pensions or financial subsidies for widows. Because she is poor, she needs to supplement her income through sex work. Poverty places her at additional risk when she is offered extra money to forgo condom use. When she has sex with truck drivers, they have the financial resources to influence the nature of their sexual activity (i.e., whether to use condoms). Despite these factors against her, Zanela has obtained condoms and has asked clients to use them. She could benefit from counseling and support to insist on condom use at all times.

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Sample answer for Case Study 4:
The fear of becoming an outcast and of shaming his family is a very powerful force that places Christopher in a vulnerable situation. He and the other men who are leading “double lives” are at risk because the denial and secrecy surrounding their sexual relationships makes it difficult for them to acknowledge their risk and to take steps to protect themselves. Christopher perceives the local health center as a place that is not equipped to respond to the needs of men like him. His fear of disclosing his sexuality may be based on the assumption that the staff at the center probably share the same views as the rest of the community on men who have sex with other men. He feels that seeking help there would only worsen his situation, and this increases his isolation and further undermines his ability to seek help and to discover ways to protect himself and others. Christopher continues to have unprotected sex with Virginia, so she too may be at increased risk of infection. Christopher’s children are also affected by the situation, because their future would be in jeopardy if one or both of their parents became ill.
Session 26
Helping Clients Make Decisions—Counseling Practice II

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

• Identify the steps in the decision-making phase of integrated SRH counseling (REDI—Phase 3, Decision making; GATHER: Help)
• List at least one open-ended question to ask clients for each of the four steps
• Describe the role of the provider in helping the client to make his or her own informed decisions and in supporting the client’s sexual and reproductive rights
• Demonstrate helping a client to make his or her own decision

**Essential Ideas—Session 26**

• In the decision-making phase of integrated SRH counseling, the provider helps the client to:
  > Focus on the key decisions he or she needs to make
  > Identify options
  > Weigh the benefits, disadvantages, and consequences of each option
  > Reach his or her own decision

• The decision-making phase of counseling is key to supporting the rights of individuals to make their own decisions regarding SRH, without pressure or coercion. One role of the provider is to determine if other people are trying to make the client do something that he or she does not want to do and to help the client reach his or her own decision.

• At the same time, the provider must be aware that he or she may be putting pressure on the client to make the decision that seems medically “correct.” While the provider’s medical opinion needs to be considered as a factor in the decision making, the client should feel that he or she has come to that choice for his or her own reasons.

• Power imbalances may exist between clients and providers, due to differences in education, social status, age, or gender. Providers need to be aware that their greater power can result in barriers to communication, as well as perceived pressure on decision making by the client.

(continued)
Essential Ideas—Session 26 (continued)

- Achieving the balance of helping a client to make a decision, without putting undue pressure on the client, has been a major challenge for providers. Providers typically either tell the client what to do or give information and leave the client on his or her own to figure out what to decide. The approach taken in this training is somewhere between those two extremes. An additional challenge is that every client will differ in terms of how much input and guidance they will need from the provider. This is why the “client-centered” approach—treating each client as an individual and basing your input on the client’s unique needs and concerns—is considered the best guidance for this step.

Discussion Summary

Research has consistently shown that helping clients to make decisions is one of the weakest areas of counseling. Why might this be true?

Fear of “motivating”—After years of promoting family planning methods or “motivating” clients to meet program targets, some providers have become reluctant to get involved in the client’s decision making. Instead, they give all of the information that they think the client needs and then let the client make his or her own choice, without questioning the client’s reasoning about the decision. The result is that clients may in fact be making their own “choices,” but it is hard to know how well-informed they are, if the provider does not clarify how or why the client reached that decision.

Embarrassment about discussing sexual issues—Decision making can be a very personal matter, particularly in areas of sexuality. Until recently, family planning providers have had little guidance for helping a client make decisions about reducing risk for HIV and STIs. Rather than embarrass themselves by asking questions about the client’s sexual behavior, in some situations providers have instead chosen to give information about HIV and STI risk and then let the client choose whether to use condoms, without questioning his or her choice.

Time pressures—Finally, busy providers are sometimes happy to see that a client arrives at the facility with a decision already made. Rather than take the time to explore whether the client is well-informed about the choice as well as about the alternatives and to find out if the client has been pressured in any way, they simply go ahead and provide the requested service.

Respecting the clients’ preference—in family planning, research has shown that clients who receive the contraceptive method that they wanted when they came to the clinic are more satisfied with their method and use it for longer than those who receive a different method. Providers may interpret this finding as a guidance to give the client what he or she wants, without checking the client’s awareness, knowledge, and reasons.